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| <p style="text-align: center;">COMMISSION OF INQUIRY<br/>ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">October 16, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. . . . . Commission Co-counsel<br/>Sandra Chaytor, Q.C. . . . . Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons . . . . . Eastern Regional Integrated<br/>. . . . . Health Authority</p> <p>Darlene Russell. . . . . Members of the Breast Cancer<br/>. . . . . Testing Class Action</p> <p>Mark Pike, Q.C. . . . . NL Medical Association<br/>Jennifer Newbury . . . . Canadian Cancer Society (NL Division)<br/>Blair Pritchett. . . . Central, Western and Labrador-Grenfell<br/>Regional Integrated Health Authorities</p> | <p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBIT P-3051 . . . . . Pg. 4</p> <p>EXHIBIT P-3055 . . . . . Pg. 4</p> <p>EXHIBIT P-3369 . . . . . Pg. 4</p> <p>EXHIBIT C-0275 . . . . . Pg. 216</p>   |
| <p style="text-align: center;">TABLE OF CONTENTS</p> <p>MS. HEATHER PREDHAM - RESUMES THE STAND</p> <p>Examination by Sandra Chaytor, Q.C. . . . . Pgs. 4 - 396</p> <p>Certificate</p>  | <p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER:</p> <p>2 Q. Please be seated. Ms. Chaytor.</p> <p>3 MS. HEATHER PREDHAM, EXAMINATION BY SANDRA CHAYTOR, Q.C.</p> <p>4 (CONT'D)</p> <p>5 CHAYTOR, Q.C.:</p> <p>6 Q. Good morning, Commissioner. Good morning, Ms.</p> <p>7 Predham.</p> <p>8 MS. PREDHAM:</p> <p>9 A. Good morning.</p> <p>10 CHAYTOR, Q.C.:</p> <p>11 Q. Commissioner, we have three new exhibits,</p> <p>12 please, this morning that I'd ask to have</p> <p>13 entered, P-3051, P-3055 and P-3369.</p> <p>14 THE COMMISSIONER:</p> <p>15 Q. Entered.</p> <p>16 EXHIBIT ENTERED AND MARKED P- 3051</p> <p>17 EXHIBIT ENTERED AND MARKED P- 3055</p> <p>18 EXHIBIT ENTERED AND MARKED P- 3369</p> <p>19 CHAYTOR, Q.C.:</p> <p>20 Q. Just bring up for a moment, please, one of the</p> <p>21 new exhibits, Registrar, P-3369. This is a</p> <p>22 document, Ms. Predham, called Risk Management</p> <p>23 Plan of Canadian Council on Health Services</p> <p>24 Accreditation that you provided us with.</p> <p>25 MS. PREDHAM:</p> |

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And I haven't had a chance to look through it,  
 4 we just got it this morning, but I'm  
 5 wondering, it doesn't have a date. Can you  
 6 tell us, is it current or -  
 7 MS. PREDHAM:  
 8 A. 2005.  
 9 CHAYTOR, Q.C.:  
 10 Q. 2005, okay, and we'll come back and perhaps  
 11 have a few questions when we have a chance to  
 12 look at it, and if we could have, please, P-  
 13 3051? This is your CV, thank you, we received  
 14 last evening, and I just want to have you go  
 15 back through some of the titles and positions  
 16 that you've held. So I think we're up to Risk  
 17 Manager at the Health Care Corporation and you  
 18 held that position, according to your CV, from  
 19 January 1998 to January 2004. Then you were  
 20 the Director of Quality and System Improvement  
 21 in an acting capacity with the Health Care  
 22 Corporation again from January 2004 to October  
 23 2006 (sic.), and then you go on to the Manager  
 24 of Quality and Risk with the Health Care  
 25 Corporation from November 2005 to June 2006,

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1 and your current position, Risk Management  
 2 Consultant/Assistant Director Quality and Risk  
 3 Management and that's with Eastern Health from  
 4 June 2006 to the present.  
 5 So perhaps we'll go back to the Risk  
 6 Manager position, Ms. Predham, and tell us  
 7 what your duties were with the Health Care  
 8 Corporation during this time period, 1998 to  
 9 2004, January 2004.  
 10 MS. PREDHAM:  
 11 A. My main duty as Risk Manager was to coordinate  
 12 any risk management activities throughout the  
 13 organization. The risk manager position, like  
 14 all of quality, Quality Initiatives, I guess,  
 15 was our department at that time, is as a  
 16 support department. So the programs are  
 17 responsible for quality and risk management  
 18 activities within their area, and we provide a  
 19 support to any programs and departments.  
 20 That being said, the risk manager then is  
 21 responsible to coordinate the occurrence  
 22 reporting system, to liaise with the insurer,  
 23 legal counsel, to manage any claims,  
 24 investigate any adverse events and also for  
 25 that period of time, I was also linked as a

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1 quality facilitator, for want of a better  
 2 term, to several departments, as part of the  
 3 Quality Initiatives department.  
 4 CHAYTOR, Q.C.:  
 5 Q. I'm sorry, what was that last part? You were  
 6 -  
 7 MS. PREDHAM:  
 8 A. The quality facilitators, as I explained  
 9 yesterday, were linked to different programs.  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes.  
 12 MS. PREDHAM:  
 13 A. But because there was only three, the risk  
 14 manager, utilization manager and the director  
 15 were linked as well. So we had that type of  
 16 support role with programs as well.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay. So in your role then, as risk manager  
 19 in this time period, who would you have been  
 20 reporting to?  
 21 MS. PREDHAM:  
 22 A. Reporting to?  
 23 CHAYTOR, Q.C.:  
 24 Q. Yes.  
 25 MS. PREDHAM:

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1 A. The director of Quality Initiatives.  
 2 CHAYTOR, Q.C.:  
 3 Q. And who held that position at that time?  
 4 MS. PREDHAM:  
 5 A. From '98 to 2000, I'm pretty sure on those  
 6 dates, it was Regina Coady, and from 2000 to  
 7 2004, it would have been Sharon Smith.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and who would have been reporting to  
 10 you, as risk manager?  
 11 MS. PREDHAM:  
 12 A. No one.  
 13 CHAYTOR, Q.C.:  
 14 Q. No one, okay, and then you move into the  
 15 Director of Quality and System Improvement,  
 16 and that's an acting capacity, for almost a  
 17 two-year period. What were your duties at  
 18 that time, and perhaps you can contrast that  
 19 and tell us how it differed from being risk  
 20 manager?  
 21 MS. PREDHAM:  
 22 A. Well, at that time, our department was  
 23 slightly different. We had three divisions.  
 24 So I had the infection control nurses reported  
 25 directly to me, so that was six frontline

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1 nurses. We also had our quality and risk  
 2 management division. So the risk manager  
 3 position became the manager of that division.  
 4 The quality facilitators reported to that  
 5 manager and that manager reported to me. Our  
 6 patient relations officer reported directly to  
 7 me, and then we had our division of management  
 8 engineering and the manager of that area  
 9 reported to me.  
 10 CHAYTOR, Q.C.:  
 11 Q. And the patient relations officer at that time  
 12 period, would that have been Nancy Parsons?  
 13 MS. PREDHAM:  
 14 A. Yes, it would have.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay. So Nancy reported directly to you in  
 17 that time period?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. And the quality facilitators reported  
 22 indirectly through?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and how was this--what was the  
 2 difference in terms of holding this position?  
 3 Were you still responsible, for example, for  
 4 investigating incidents or occurrences and did  
 5 you still have that liaison with the insurer  
 6 during this period of time?  
 7 MS. PREDHAM:  
 8 A. Not as directly. From the period of 2002,  
 9 probably the end of 2001 to 2004, we went  
 10 through a great deal of turnover in the  
 11 Quality department, and as risk manager, I  
 12 took a lot of--a lot more responsibility or,  
 13 you know, for investigating complaints because  
 14 we had new staff in the quality facilitator  
 15 roles. So we had a great deal of turnover  
 16 during that period of time. So when, in  
 17 January 2004, we had a relatively very new  
 18 staff in as quality risk management. So I was  
 19 more hands on than I would have been if we had  
 20 more experienced staff in that area.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, and so in terms of then the liaison with  
 23 the insurer or the lawyers handling any  
 24 particular claim, who would have had that  
 25 role?

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1 MS. PREDHAM:  
 2 A. The manager of quality and risk management.  
 3 CHAYTOR, Q.C.:  
 4 Q. And who was that?  
 5 MS. PREDHAM:  
 6 A. That was Pamela King-Jesso.  
 7 CHAYTOR, Q.C.:  
 8 Q. Pamela King-Jesso, and with respect though to  
 9 the ER/PR issue, which occurred within this  
 10 period, it comes up in the spring of 2005, who  
 11 had the liaison role for that particular  
 12 issue?  
 13 MS. PREDHAM:  
 14 A. At that time, Ms. King-Jesso was off for a  
 15 period of time, so I was in that role in her  
 16 stead for a bit of that.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, and did you continue on then in that  
 19 role?  
 20 MS. PREDHAM:  
 21 A. She left the department in September of '05.  
 22 So yes, I carried on then.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay. So for our purposes here in dealing  
 25 with the ER/PR issue, you are the person who

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1 would have been the liaison with the insurer  
 2 or with the solicitors handling any claims  
 3 arising from the ER/PR issue?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, and in terms then also of the other  
 8 issues that you would have been dealing with  
 9 had you held Ms. King-Jesso's role, with  
 10 respect to ER/PR, were you also the person  
 11 then who continued on in her capacity with  
 12 respect to, for example, investigating any  
 13 investigation that needed to take place, any  
 14 occurrence reporting, who was handling that  
 15 for the ER/PR issue?  
 16 MS. PREDHAM:  
 17 A. After when she left in September?  
 18 CHAYTOR, Q.C.:  
 19 Q. Yes.  
 20 MS. PREDHAM:  
 21 A. We did--well, we had a very small department  
 22 at that time, and it was--we were becoming  
 23 Eastern Health, so we were getting requests  
 24 from the new parts of Eastern Health that we  
 25 weren't familiar with, and the various quality

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1 people in the legacy boards had left. The  
 2 majority of them had left and gone to other  
 3 positions, so between the people who remained  
 4 in the quality and risk management division,  
 5 we divvied it up between us.  
 6 CHAYTOR, Q.C.:  
 7 Q. So her position wasn't filled when she left?  
 8 MS. PREDHAM:  
 9 A. No, because that was September 2005.  
 10 CHAYTOR, Q.C.:  
 11 Q. So then from September 2005, when does the  
 12 position then get filled?  
 13 MS. PREDHAM:  
 14 A. Until June.  
 15 CHAYTOR, Q.C.:  
 16 Q. June of 2006?  
 17 MS. PREDHAM:  
 18 A. 2006.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and so then that's the role that you  
 21 take on as risk manager, management  
 22 consultant, assistant director of quality and  
 23 risk management, and you take that on in June  
 24 2006?  
 25 MS. PREDHAM:

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1 A. Yes. Now it's a little bit different. It  
 2 seems like there's provisos for everything I  
 3 say here, but the way the department is  
 4 structured now, the quality safety leaders,  
 5 which would be the type of quality facilitator  
 6 position, has a primary role for risk  
 7 management and investigation and complaints.  
 8 The difficulty was, in June of 2006, the  
 9 majority of those staff were new to this area  
 10 and required a lot of direction. So the risk  
 11 management consultant position is intended to  
 12 be that, not hands on into the investigation  
 13 part, but, you know, for the next year or so,  
 14 it had to be that because you had a lot of new  
 15 staff who had to learn how to do this.  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes, okay. So I just want to be clear in  
 18 terms of--because we don't see Ms. King-  
 19 Jesso's name doesn't appear very often in the  
 20 documentation that we're dealing with.  
 21 MS. PREDHAM:  
 22 A. No.  
 23 CHAYTOR, Q.C.:  
 24 Q. So in terms of you're saying she left in  
 25 September 2005, but was she ever tasked with

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1 any risk management, in terms of the ER/PR  
 2 issue?  
 3 MS. PREDHAM:  
 4 A. No. When it first came up, she was off, and  
 5 when she came back, she had, I guess, a  
 6 limited ability to--she had to be limited in  
 7 her activities at that time. So where she was  
 8 off when it started, it was just as well for  
 9 me to carry on at that time.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay, and so she had been off for some period  
 12 of time and while she was off, you were  
 13 carrying out her duties?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, and so in this period of time here that  
 18 we see when you were acting director of  
 19 Quality and Systems Improvement from January  
 20 2004, is this--when, I guess--my question is  
 21 when did you start carrying out her duties? Is  
 22 this it?  
 23 MS. PREDHAM:  
 24 A. No.  
 25 CHAYTOR, Q.C.:

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1 Q. This is a different position?  
 2 MS. PREDHAM:  
 3 A. It was during that position. It would  
 4 probably have been in June of 2005, and  
 5 carrying out her duties, I guess there was a  
 6 very small group of us and it was--we picked  
 7 up her duties amongst us. So anything that  
 8 had to be done, the quality facilitators were  
 9 taking that role as well of liaisoning with  
 10 the risk management, with the insurer and with  
 11 the lawyers for the areas they were  
 12 responsible with. But it would have been--she  
 13 would have been, you know, fully acting in  
 14 that role from January 2004 until -  
 15 CHAYTOR, Q.C.:  
 16 Q. She went on leave in June of 2005?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and so, and the position that you're in  
 21 here as Director of Quality and Systems  
 22 Improvement in an acting position -  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. - you then, in fact, take on a second acting  
 2 position as of June 2005, in essence?  
 3 MS. PREDHAM:  
 4 A. In essence.  
 5 CHAYTOR, Q.C.:  
 6 Q. In essence, without the formal title, I guess,  
 7 you take on -  
 8 MS. PREDHAM:  
 9 A. No. Well, we -  
 10 CHAYTOR, Q.C.:  
 11 Q. - you take on her duties as well?  
 12 MS. PREDHAM:  
 13 A. Well, part of her duties. Like I said, the  
 14 other quality facilitators took on part of  
 15 those duties as well.  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes, okay. Then the position that you take up  
 18 in--okay, so the manager of quality and risk,  
 19 from November 2005 to June 2006 -  
 20 MS. PREDHAM:  
 21 A. That was Ms. King-Jesso's position.  
 22 CHAYTOR, Q.C.:  
 23 Q. That's her position, and that's when you take  
 24 on your second--and although it says November  
 25 2005 here, you're saying that the reality is

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1 that you took on a lot of those duties in June  
 2 of 2005?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And is there any difference in what you would  
 7 have been doing as the manager of quality and  
 8 risk and what you were doing as the risk  
 9 manager for the Health Care Corporation from  
 10 1998 to January 2004?  
 11 MS. PREDHAM:  
 12 A. Well, yes, because the quality facilitators  
 13 reported to the manager of quality and risk  
 14 and you weren't solely responsible for risk  
 15 management activities there. Although the  
 16 risk manager was linked as a quality  
 17 facilitator role with certain programs, now  
 18 you were manager of the three quality  
 19 facilitators and you had to--you know, you  
 20 were responsible for quality activities and  
 21 the risk management activities.  
 22 CHAYTOR, Q.C.:  
 23 Q. So you were responsible then for both?  
 24 MS. PREDHAM:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. And you then had the quality facilitators  
 3 reporting to you?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. So was this a--when I hear that, it sounds  
 8 like there were additional duties. You still  
 9 had all the duties you had as risk manager and  
 10 then you also became responsible for quality  
 11 and had people then directly reporting to you?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. So it was additional duties added on as of  
 16 November 2005?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay. Then that brings us to your current  
 21 position, which you took up in June of 2006  
 22 and perhaps you can tell us what, if any,  
 23 differences there were in your duties in your  
 24 current position.  
 25 MS. PREDHAM:

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1 A. Well, as assistant director, I would be  
 2 assisting the director in activities that help  
 3 run the entire department. I also have  
 4 infection control report directly to me and  
 5 that would be the manager of infection  
 6 control, rather than the frontline nurses, and  
 7 then the intent is the position would be more  
 8 of a consultant role to risk management and  
 9 would move more into proactive activities,  
 10 rather than just solely reactive. Also, as  
 11 time went on, we have two new positions that  
 12 report to me as well, the quality information  
 13 coordinator and the claims manager, and they  
 14 report to me.  
 15 CHAYTOR, Q.C.:  
 16 Q. And when did the quality information manager  
 17 position come on?  
 18 MS. PREDHAM:  
 19 A. October 2006.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay, and the other one was the claims  
 22 manager?  
 23 MS. PREDHAM:  
 24 A. Claims manager.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and when was that position put in place?  
 2 MS. PREDHAM:  
 3 A. February 2007.  
 4 CHAYTOR, Q.C.:  
 5 Q. And who do you report to in your current  
 6 position?  
 7 MS. PREDHAM:  
 8 A. The Director of Quality and Risk Management.  
 9 CHAYTOR, Q.C.:  
 10 Q. And that person is?  
 11 MS. PREDHAM:  
 12 A. Pam Elliott.  
 13 CHAYTOR, Q.C.:  
 14 Q. And while you were manager of quality and risk  
 15 and director of quality and system improvement  
 16 in your acting capacity, who were you  
 17 reporting to in these positions?  
 18 MS. PREDHAM:  
 19 A. As the acting director, I reported to Pat  
 20 Pilgrim. Well, yes, I reported to Pat  
 21 Pilgrim, and as the manager in quality risk, I  
 22 reported to Pam Elliott because she had just--  
 23 she started as the Regional Director for  
 24 Quality and Risk Management.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and she started her position the same  
 2 time you started yours, in November 2005?  
 3 MS. PREDHAM:  
 4 A. Yes, because when I--when she started in her  
 5 position, then I moved back to my previous  
 6 position, which was different.  
 7 CHAYTOR, Q.C.:  
 8 Q. Yes. So once Ms. Elliott took on her  
 9 position, you, in essence, went back to the  
 10 risk management position?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. With the additional responsibilities. So then  
 15 did Ms. Elliott become the manager of quality  
 16 and risk?  
 17 MS. PREDHAM:  
 18 A. No, she was a regional director.  
 19 CHAYTOR, Q.C.:  
 20 Q. Regional director, okay. So you were  
 21 reporting to her and had been reporting to her  
 22 since November 2005?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. And with respect to the ER/PR issue, from June  
 2 of 2005 until Ms. Elliott is in her position  
 3 in November 2005, would you have been  
 4 reporting to Ms. Pilgrim?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And did you report to anyone else on that  
 9 issue?  
 10 MS. PREDHAM:  
 11 A. Well, Dr. Williams took the lead on that  
 12 issue. So he coordinated activities.  
 13 CHAYTOR, Q.C.:  
 14 Q. So I would take it then, you would take  
 15 direction or instruction from either Dr.  
 16 Williams or Ms. Pilgrim?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, thank you, I think that's clearer for  
 21 us. I'd like to go back and ask you a few  
 22 questions of a few terms that came up  
 23 yesterday when we started on your educational  
 24 background.  
 25 MS. PREDHAM:

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1 A. Certainly.  
 2 CHAYTOR, Q.C.:  
 3 Q. And one issue that came up was root cause  
 4 analysis, and I believe you indicated that  
 5 that was something that you studied in the--  
 6 was it the year-long correspondence course  
 7 that you completed?  
 8 MS. PREDHAM:  
 9 A. No, that's a--I guess it really came to a head  
 10 or really came to the forefront during the  
 11 patient safety movement and that was more in  
 12 the 2000's that that was coming forefront.  
 13 Root cause analysis is a technique to  
 14 investigate and get to the root cause of an  
 15 adverse event, and during this period of time  
 16 when I was risk manager, myself and the risk  
 17 manager at Western Health, we founded a risk  
 18 management network across the province, and we  
 19 were having difficulty, as a group, getting  
 20 education in root cause analysis because it  
 21 was a tool that you could benefit from using.  
 22 Well, we were using it as well as we could  
 23 from, you know, doing our own education, and  
 24 we were having difficulty getting funding and  
 25 training. So we arranged a train-the-trainer

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1 session with the Institute for Safe Medication  
 2 Practice and CPSI to come down and hold a  
 3 train-the-trainer session here in 2005  
 4 actually, November 2005.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, and the issue, I think you referred to a  
 7 fishbone diagram.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. And perhaps you could explain to us what that  
 12 is and how that is a tool that's sometimes  
 13 used?  
 14 MS. PREDHAM:  
 15 A. When you investigate--it doesn't have to be an  
 16 adverse event. If you're involved in quality  
 17 and you're doing a process improvement team as  
 18 a quality project, you know, that there's some  
 19 difficulty or something you want to get  
 20 involved in. There's various tools that you  
 21 can use to help illustrate or get to the root  
 22 of the problem. A fishbone diagram would be a  
 23 cause and effect type of tool in which, you  
 24 know, you have your issue or your process and  
 25 then you're looking at various things that

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1 could contribute and influence that process.  
 2 So it's just one of those tools that you can  
 3 use to--when you have your team, that you can  
 4 illustrate that and kind of focus your  
 5 activity.  
 6 CHAYTOR, Q.C.:  
 7 Q. And again, and the purpose being to try and  
 8 identify any issues, whether it's quality,  
 9 ongoing quality exercise or whether it is to  
 10 investigate an occurrence?  
 11 MS. PREDHAM:  
 12 A. Right. When you have a team together, you  
 13 have like a lot of frontline staff and when  
 14 you're investigating something and a lot of  
 15 times, it's--I know myself, I'm a very  
 16 concrete thinker. I like seeing things laid  
 17 out, and it's easier when you have a group for  
 18 them to see that, you know, especially if  
 19 they're doing a process for a long time, there  
 20 tends to be, you know, with anything, you tend  
 21 to get used to that and comfortable with that  
 22 process. So until you have someone like  
 23 myself coming from outside and asking a lot of  
 24 questions and getting them to work through  
 25 that process, they're usually too close to

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1 that, that they could see these are  
 2 contributing factors.  
 3 So something like a cause and effect, a  
 4 fishbone diagram, can help them actually see,  
 5 yes, okay, there's the problem here or  
 6 whatever, when they haven't stopped and looked  
 7 at it that way.  
 8 CHAYTOR, Q.C.:  
 9 Q. Right, so you come in with an independent  
 10 objective perspective and lay it out for them  
 11 and you use this sort of fishbone diagram to  
 12 assist?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay. If we could look, please, bring up P-  
 17 3075? And this, Ms. Predham, is a performance  
 18 evaluation for the time period January 2006 to  
 19 September 2007. So again, that would cover  
 20 the period of--I guess it overlaps, you're in  
 21 the manager quality and risk portfolio and  
 22 then into your current position, and I'll just  
 23 bring up in terms of what it indicates to be  
 24 your primary job responsibilities on this  
 25 diagram, and it says "provides guidance and

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1 direction to staff and physicians regarding  
 2 risk management issues and activities, leads  
 3 and facilitates process improvement teams and  
 4 investigation of adverse events." So is that  
 5 an accurate description of what you would have  
 6 been doing in this time period, from January  
 7 2006 to September 2007?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay, and perhaps you can just tell us what is  
 12 the process improvement teams? What's their  
 13 roles? What's the role of a process  
 14 improvement team?  
 15 MS. PREDHAM:  
 16 A. At its very fundamental, if you have a  
 17 problem, and I guess it leads back to when I  
 18 mentioned Edward Demmings' work yesterday.  
 19 His process or his philosophy and his basis of  
 20 CQI is this 80/20 rule. Sometimes it's cited  
 21 as 85/15 rule. That 85 percent of the time or  
 22 80 percent of the time, if you're having a  
 23 problem, you're having a problem because of  
 24 the way things are done, not the people that  
 25 are actually doing it. So that is the

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1 fundamental philosophy behind quality  
 2 improvement, and our whole department, almost  
 3 everything that we do. Now my experience is  
 4 more like it's 95 rather than 85 percent, but  
 5 so with that focus, when you go into these  
 6 things, it's very important to look at the way  
 7 that things are done. So a process improvement  
 8 team looks at the way things are done and then  
 9 tries to determine how to improve it, based on  
 10 that whole process.

11 The idea now is more in systems theories  
 12 is how it's referred to and I know you've  
 13 heard discussion about the swiss cheese model  
 14 and that type of thing. So that's the  
 15 fundamental philosophy behind it. So a  
 16 process improvement team would lay out the  
 17 process the way it is now and go through some  
 18 method, whether it's fishbone diagram, a flow  
 19 chart or anything, to identify where problems  
 20 are and then how can we improve it, and then  
 21 implement that or make a proposal for  
 22 implementation and then find out some way to  
 23 evaluate it.

24 CHAYTOR, Q.C.:  
 25 Q. And are they only put in place if an incident

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1 occurs or are they used proactively to try and  
 2 identify if there is an issue?

3 MS. PREDHAM:  
 4 A. Well, a process improvement team usually  
 5 there's something. It may not be an incident.  
 6 It could be, you know, that there's some flow  
 7 problems or there's usually something which  
 8 would cause that there, but the big tool now,  
 9 as a proactive one, would be a failure mode  
 10 effects analysis, and really that's the same  
 11 type of concept.

12 THE COMMISSIONER:  
 13 Q. I'm sorry, what was that again?

14 MS. PREDHAM:  
 15 A. A failure mode effects analysis.

16 THE COMMISSIONER:  
 17 Q. Failure mode effects analysis?

18 MS. PREDHAM:  
 19 A. Yes.

20 THE COMMISSIONER:  
 21 Q. Thank you.

22 MS. PREDHAM:  
 23 A. It's an engineering tool and it is, you plot  
 24 out your process right through and then you,  
 25 as a group, you try to look at the higher risk

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1 areas or the more problem prone that you're  
 2 anticipating and the whole thing is that  
 3 you're doing this proactively, so before this  
 4 process gets in place. So if a new program is  
 5 coming in or a new test is being done or  
 6 something like that, you'd sit down with the  
 7 key people involved and you'd facilitate them  
 8 speaking about how is this going to work, and  
 9 you'd have to go into great detail on that,  
 10 and then once you pick out those areas, then  
 11 you have to say okay, what can go wrong at  
 12 each one of these steps. So it's a lot of  
 13 brain storming. It's a lot of forcing these  
 14 people to--not forcing them, but you know,  
 15 facilitating them to think about, "okay, if we  
 16 do this, what can go wrong?" So then there's  
 17 a rating--there's tools to help you rate that  
 18 and you identify the areas where you have to  
 19 rate that and then the highest--you'd focus in  
 20 on those highest problem prone ones and you'd  
 21 put things in to prevent it from happening.

22 CHAYTOR, Q.C.:  
 23 Q. Okay. So for example, back in 1997/1998 when  
 24 ER/PR was switching over to the IHC method, if  
 25 there had been such a thing as failure mode

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1 effects analysis, at that point in time, you  
 2 could have sat down with the people involved  
 3 in the process, the pathologists,  
 4 technologists, the people bringing this on,  
 5 and go through and try and identify any  
 6 particular issues or problems that might  
 7 arise?

8 MS. PREDHAM:  
 9 A. If it had been around, yeah.

10 CHAYTOR, Q.C.:  
 11 Q. Yes.

12 MS. PREDHAM:  
 13 A. And that's what it's designed to do. The  
 14 difficulty is that it's very intensive. So  
 15 you have to have the resources to be able to  
 16 do it, but you also have to have that lead  
 17 time. You need to take the time and have the  
 18 time to do it before the program gets in. So  
 19 it's really important that the leadership and,  
 20 you know, the organization throughout knows  
 21 about this tool, rather than us, because when  
 22 we find out that something is starting, you've  
 23 got a very short time. It's when something is  
 24 being conceived that, okay, we'd like to start  
 25 doing this. That's when you'd like to do



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1 that.

2 CHAYTOR, Q.C.:

3 Q. Okay, and was there--while there was no

4 failure mode effects analysis back in that

5 time period, was there a similar tool that was

6 being used in the quality and risk management

7 world for doing such assessments?

8 MS. PREDHAM:

9 A. Not before, not that proactive, that side. We

10 would do a process improvement team, but

11 again, there was usually some problem or some,

12 you know, near miss, you know, that type of

13 thing that would cause that, or some backlog

14 or patient complaint or something that would

15 cause us to look at an issue.

16 CHAYTOR, Q.C.:

17 Q. So if there were a new test coming on in your

18 institution or a new way of doing things,

19 there was no--none of that kind of proactive

20 assessment beforehand?

21 MS. PREDHAM:

22 A. Oh no, I'm not saying--no, I'm not saying

23 that. The people responsible for that would

24 do that, but it wouldn't be that systematic

25 looking through that in a very, you know,

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1 systematic flow charty way. They would do

2 that, they would assess that, the process as

3 they go through, but it would be a proposal

4 stage and people would be looking at it.

5 They'd be doing the research, you know, all

6 that kind of thing, but it wouldn't be that

7 systematic plotting out of the process and

8 getting the frontline staff to sit down and

9 say "what would you anticipate your process is

10 going to be?" and you know, it's that level of

11 detail.

12 CHAYTOR, Q.C.:

13 Q. And was there any system in place where your

14 department or the quality department and risk

15 department would have been involved?

16 MS. PREDHAM:

17 A. Back in '97/98 when a new system -

18 CHAYTOR, Q.C.:

19 Q. Yes.

20 MS. PREDHAM:

21 A. Not necessarily. It would be if the program

22 director involved us, you know, there could

23 be. We would be involved, but unless they

24 did, we wouldn't.

25 CHAYTOR, Q.C.:

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1 Q. Okay, and do you know whether or not anybody

2 was involved, from your department, in setting

3 up the ER/PR in 1997?

4 MS. PREDHAM:

5 A. Oh no.

6 CHAYTOR, Q.C.:

7 Q. There was no one involved?

8 MS. PREDHAM:

9 A. No.

10 CHAYTOR, Q.C.:

11 Q. Okay, in terms of -

12 THE COMMISSIONER:

13 Q. Wait now, I just want to make sure I

14 understand. Your description of the failure

15 mode effect analysis, is there really any

16 difference in what you do in that and what you

17 would be doing following either an adverse

18 event or a request by a department, because

19 they were concerned about something, other

20 than the timing?

21 MS. PREDHAM:

22 A. Well, I guess the biggest difference, other

23 than it's before, is that also you're

24 anticipating what you're going to do, because

25 the processes haven't been set up yet. So you

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1 have to get people to really say how would you

2 do this, how would you work through this, how

3 would you do that. So you're not actually

4 saying "what do you do?" You're just going to

5 say "what would you do if this went in this

6 way?" So I guess that's the biggest

7 difference.

8 THE COMMISSIONER:

9 Q. All right. But essentially, it's the same

10 process, it seems to me. It is what are the

11 steps, either anticipated by virtue of what

12 you're bringing them in or what are the steps

13 that you are actually doing, A, B, C, D, E in

14 analysing the--presumably the actions taken in

15 the persons who are taking the action, roles,

16 etcetera, etcetera, to determine whether or

17 not it is the, I presume, best, most

18 efficient, safest, are those your goals?

19 MS. PREDHAM:

20 A. Are those our goals? Yes.

21 THE COMMISSIONER:

22 Q. Okay.

23 MS. PREDHAM:

24 A. Well, the safest would be the ultimate goal.

25 CHAYTOR, Q.C.:

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1 Q. And Ms. Predham, while this is the interim  
 2 performance appraisal indicated from January  
 3 2006 through September 2007, insofar as you  
 4 assumed the role of Manager Quality and Risk  
 5 in an acting capacity from June of 2005, would  
 6 those have been your same primary job  
 7 responsibilities, from June 2005 onwards?  
 8 MS. PREDHAM:  
 9 A. Well, no, because I had the entire--as acting  
 10 director, I had the entire department. So I  
 11 had to manage frontline nursing staff in  
 12 infection control. I also had a management  
 13 engineering division. So although I was  
 14 involved in issues like that, I totally relied  
 15 on the quality facilitators to assist me in  
 16 that and take on part of that.  
 17 CHAYTOR, Q.C.:  
 18 Q. So it would be this plus the other?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And the process improvement teams, those come  
 23 in place, I understand, those can be either  
 24 looking for some area to improve or they can  
 25 come into place after an event or an

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1 occurrence to try and investigate well, why  
 2 did this event take place?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And was there a process improvement team put  
 7 in place with respect to the ER/PR issue?  
 8 MS. PREDHAM:  
 9 A. ER/PR was a very different process because it  
 10 was very large. Every time there's an adverse  
 11 event, you kind of have to look at what you're  
 12 going to do or how you're going to investigate  
 13 it, and ER/PR was a little bit different on  
 14 all aspects, even going down, when I did the  
 15 quality review or went down to start the  
 16 quality review in August of 2005. That was  
 17 mostly, you know, how would we look into this,  
 18 how would we go into this process, and it was  
 19 very difficult because the process that they  
 20 were using was not the process that we were  
 21 most concerned about. So, you know, you  
 22 couldn't even go through that step by step as  
 23 much. So it wasn't a formal process  
 24 improvement team that we had here, because,  
 25 you know, there was a lot of, not

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1 disagreement, but a lot of information that,  
 2 you know, to varying what we were dealing  
 3 with, I guess is the thing.  
 4 So from July when I got into the details  
 5 of it to August when I went down into the lab,  
 6 there was a lot of different factors that were  
 7 being talked about of what was really here at  
 8 play, and when I went down to the lab to do  
 9 that, it was--I wouldn't have been able to do  
 10 a good quality review. It needed to have lab  
 11 people to do that, needed to have a skill set  
 12 and for our comfort level, we had to go  
 13 outside like we did.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and I'll take you through that as we go  
 16 through. So in terms of usually a process  
 17 improvement team, would that normally though  
 18 be people who are involved in the particular  
 19 program?  
 20 MS. PREDHAM:  
 21 A. Well, yes, because they're the ones who have  
 22 to tell you what you've actually done. You  
 23 know, if there's been a miscommunication issue  
 24 and that is especially key when you have a  
 25 large organization, but also when, you know,

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1 like back in '96, '97, '98 when we were  
 2 forming the Health Care Corp and of course, in  
 3 the past few years with Eastern Health, you  
 4 have a large organization that's busy and  
 5 complex anyway and then you're merging it with  
 6 other busy, complex organizations. So  
 7 especially at times like that, it's very  
 8 important to have everyone around because  
 9 that's the way things happen. It gets a bit  
 10 tangly when you start changing things on the  
 11 outside. So it's very important to find out  
 12 what's going on as you're going through that  
 13 process.  
 14 CHAYTOR, Q.C.:  
 15 Q. So in terms of not doing anything internally  
 16 with actually setting up a process improvement  
 17 team, I can understand, and I'll take you  
 18 through the decision to go outside and have  
 19 external reviews carried out, but the decision  
 20 not to have then anything in the way of from  
 21 within examining what was happening was  
 22 because there was--is it too complicated or  
 23 there's communication issues? Why couldn't  
 24 there be both?  
 25 MS. PREDHAM:

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1 A. Well, I think there was a variety of factors  
 2 at the time. You know, we had a--I remember  
 3 investigating an adverse event a couple of  
 4 years ago where we watched the staff go  
 5 through a process with the equipment, just to  
 6 get a feel of that. So you didn't have that  
 7 ability here, because at the time, we were--  
 8 you know, you had the DAKO--the process, the  
 9 manual system of the process with the DAKO  
 10 system was of concern, because if you have any  
 11 kind of manual process the staff are doing,  
 12 you know, you have that risk of human error  
 13 anyway. So you didn't have that same process  
 14 as they were going through.  
 15 At the time, we also--we stopped  
 16 retesting, so it wasn't like the pressure  
 17 wasn't on us to fix it right now. We had that  
 18 ability to bring somebody in and review it  
 19 from external and then assess it from there.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay. The occurrence reporting system, and  
 22 you would have been responsible for the  
 23 occurrence reporting system in your risk  
 24 management portfolio?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And would they, the reports that would come  
 4 forward, occurrence reporting, they would go  
 5 to your department?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And what would you then do with them?  
 10 MS. PREDHAM:  
 11 A. Well, everyone--in our department, everyone is  
 12 linked to a program and whoever gets the  
 13 occurrence reports for those programs would  
 14 review them. They've already been reviewed by  
 15 the manager of that area and in some areas,  
 16 been reviewed by the program director, and  
 17 then we would get that. Review them for any  
 18 action that needs to be taken immediately, and  
 19 then go through--code them, so they can be  
 20 entered into the database. Then they would  
 21 get entered into the database and then reports  
 22 would be generated.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay, and just one question back to the  
 25 failure mode effects analysis. When did that

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1 become a tool that you would use?  
 2 MS. PREDHAM:  
 3 A. We started seeing that appearing in the  
 4 literature probably the end of 2004, somewhere  
 5 2005, and in the spring of 2006, we asked ISMP  
 6 to come down and do that train-the-trainer  
 7 session again for us.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and in terms of the--you would also have  
 10 had responsibility for the, it says,  
 11 investigation of adverse events. What was in  
 12 place in terms of policies in the Health Care  
 13 Corporation which required the reporting of  
 14 adverse events?  
 15 MS. PREDHAM:  
 16 A. Well, we had the occurrence reporting policy  
 17 and then I think in '98, might have been 2000,  
 18 we also had the critical occurrence policy.  
 19 THE COMMISSIONER:  
 20 Q. I'm sorry, the what?  
 21 MS. PREDHAM:  
 22 A. Critical occurrence policy.  
 23 THE COMMISSIONER:  
 24 Q. Critical, thank you.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and when you took on your role as risk  
 2 manager originally in 1998, would you have  
 3 been--were those policies in place at that  
 4 time?  
 5 MS. PREDHAM:  
 6 A. The occurrence reporting policy was in place.  
 7 I was part of the development of that as a  
 8 quality facilitator, but that was in place  
 9 then in '98, and the critical occurrence  
 10 policy, we put that in place--I guess we had a  
 11 fairly significant incident and we had--the  
 12 way the incident went, it crossed a couple of  
 13 programs. The program directors happened to  
 14 be on holidays at that time and there was a  
 15 lot of miscommunication in the--there was no  
 16 coordination in the handling of it. It was a  
 17 very unique situation, but at the time, we  
 18 felt that there needed to be something else to  
 19 kind of give guidance to people when something  
 20 significant happens, something you couldn't  
 21 rely on an occurrence report. You needed that  
 22 quick notification, you know, immediate  
 23 notification, that pulling together everybody  
 24 immediately, and moving on from there.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, so perhaps then is the difference  
 2 between occurrence reporting, and the critical  
 3 occurrence reporting which you've brought in,  
 4 is it the magnitude and urgency of the  
 5 situation?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. So what would you expect to show up in an  
 10 occurrence report, what types of incidents?  
 11 MS. PREDHAM:  
 12 A. An occurrence report is very broad.  
 13 Fundamentally, it's anything unexpected,  
 14 something that you couldn't anticipate. If  
 15 anything didn't follow policy like a  
 16 medication occurrence, so if medications were  
 17 mislabelled, if they were given to the wrong  
 18 patient or the wrong time or they weren't  
 19 given, you know, could be any of those  
 20 varieties, slip and fall, property loss,  
 21 property damage, a fire, elopement, you know,  
 22 the very broad numerous ones. Each program  
 23 and department has been encouraged to identify  
 24 occurrences in their area themselves, so  
 25 what's important to them. It's not

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1 necessarily something in the routine of their  
 2 work as an occurrence. Like, they need to  
 3 have that discussion with their frontline  
 4 staff of what is an occurrence to them. For  
 5 example, in diagnostic imaging, if you come in  
 6 to get a CT scan and you have to get contrast,  
 7 the DI tech will ask you have you ever had a  
 8 CT scan before, have you had contrast before,  
 9 are you allergic to anything. So if you're  
 10 not allergic to anything and you never had  
 11 this before, you never had a contrast before,  
 12 and then you broke out in hives, well, that's  
 13 an adverse reaction to the contrast, but it's  
 14 not an occurrence because it's an anticipated  
 15 implication of this. Now if you came in and  
 16 you did have that and it's on your chart that  
 17 you're allergic to contrast and we gave it to  
 18 you, anyway, that's an occurrence.  
 19 CHAYTOR, Q.C.:  
 20 Q. That's an incident, right, okay.  
 21 MS. PREDHAM:  
 22 A. Yeah.  
 23 CHAYTOR, Q.C.:  
 24 Q. So someone getting the wrong medication would  
 25 be an occurrence?

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And you'd expect an occurrence report to go  
 5 forward?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And so then the critical occurrence would be  
 10 what, what's the difference?  
 11 MS. PREDHAM:  
 12 A. Well, something very significant that requires  
 13 immediate reaction. So if it's somebody--a  
 14 patient is severely harmed or there's a  
 15 potential that you think that the patient may  
 16 be harmed, that, you know--I mean,  
 17 fundamentally that's the critical occurrence,  
 18 around patient harm, but anything of that  
 19 nature.  
 20 CHAYTOR, Q.C.:  
 21 Q. So imminent danger to a person?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. So when you came into the position, you were

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1 instrumental then in bringing in a critical  
 2 occurrence policy?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And how do you educate the staff that they  
 7 should be filling out occurrence reports when  
 8 those incidents arise?  
 9 MS. PREDHAM:  
 10 A. Well, it's a continual thing. We've done a  
 11 lot of occurrence reporting education over the  
 12 year in--we do them every now and then as it  
 13 goes on. We do--whenever there's a change to  
 14 the form or anything, we've done education  
 15 sessions to all staff or as many staff as we  
 16 can, but a very systematic scheduled  
 17 throughout the organization. Any new staff  
 18 who come in get information on occurrence  
 19 reporting in the orientation. Medical  
 20 students, nursing students, they all get  
 21 occurrence reporting education.  
 22 CHAYTOR, Q.C.:  
 23 Q. And would you expect occurrence reports to not  
 24 only cover actual occurrences, but the near  
 25 miss situation? The patient didn't get the

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1 wrong medication, but may have had they  
 2 followed through and not caught it?  
 3 MS. PREDHAM:  
 4 A. And that's why it's called occurrence rather  
 5 than incident reporting. Back in '96 when we  
 6 came together, several of the sites used the  
 7 term "incident reporting" and that implies  
 8 that something has happened. So we went with  
 9 the term "occurrence reporting" because that  
 10 was--an occurrence could be something that  
 11 didn't actually reach the patient, so it is  
 12 that near miss, but that wasn't the  
 13 terminology that we had at the time.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and what would you have been calling it  
 16 at that time?  
 17 MS. PREDHAM:  
 18 A. Well, it was an occurrence that included the  
 19 near miss, but near miss is more of a patient  
 20 safety term that came out in the 2000s.  
 21 CHAYTOR, Q.C.:  
 22 Q. And has that improved over time in terms of--  
 23 the time period we're looking at here is from  
 24 1997 through to 2005. Has the sophistication  
 25 of education of the staff improved in terms of

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1 their awareness of the importance of reporting  
 2 occurrences?  
 3 MS. PREDHAM:  
 4 A. Well, we hope so because we continually do  
 5 them. Now I can only speak to Health Care  
 6 Corporation, but we've done a lot of education  
 7 and when patient safety is--patient safety  
 8 movement was coming, and once we understood,  
 9 you know, the concepts that are in there, it's  
 10 even more critical that frontline staff be  
 11 aware of that. So we've done a lot of  
 12 education over the years on occurrence  
 13 reporting, patient safety, system error,  
 14 individual error. We do that with a lot of  
 15 areas, we do it with a lot of med students,  
 16 nursing students. You know, every year I  
 17 speak to nursing students about occurrence  
 18 reporting, patient safety, individual error.  
 19 I do orientation with the med students when  
 20 they come to work with Eastern Health now, but  
 21 with the Health Care Corporation. I do--every  
 22 two years I do education on this with medical  
 23 residents, and I've done numerous in services  
 24 throughout, both with professional practice  
 25 groups--so I would do a session with social

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1 workers or a session with physiotherapists,  
 2 and then with the various areas, you know,  
 3 they have an education day and we get asked to  
 4 come and present at those.  
 5 CHAYTOR, Q.C.:  
 6 Q. So have you seen improvement with all your  
 7 efforts over the years, has there been  
 8 improvement?  
 9 MS. PREDHAM:  
 10 A. Yes, I--in 2004, we did a proposal in--we had  
 11 an internal award system within the Health  
 12 Care Corporation, a purple and green award,  
 13 and for the life of me right now, I can't  
 14 remember the difference between the two, but  
 15 they were a monetary award that you got. It's  
 16 a Board initiative to do some kind of process  
 17 that you would not normally, you know, have  
 18 the funding to do. So we applied for one or  
 19 the other of them and got money to launch a  
 20 patient safety plan. So in anticipation of  
 21 that, we had done focus groups with our staff,  
 22 talking about patient safety, and looking at  
 23 what were the key issues that they were  
 24 discovering, and then we developed a plan. We  
 25 had a committee, we had a logo, the branding,

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1 so we had the money to do all those nice  
 2 things, and we launched that with a big  
 3 conference during patient safety week. I do  
 4 believe it was patient safety week.  
 5 CHAYTOR, Q.C.:  
 6 Q. And when was this?  
 7 MS. PREDHAM:  
 8 A. That was in 2004. So then every year we tried  
 9 to have a conference as well to bring down a  
 10 national level speaker talking about patient  
 11 safety, open it for all staff. So it has been  
 12 more focused since 2004, but before that, we  
 13 also tried to do that and a lot of the work  
 14 that went into that came from that risk  
 15 management network I mentioned that we tried  
 16 to get national speakers down talking to us  
 17 about this type of issue.  
 18 CHAYTOR, Q.C.:  
 19 Q. Is there also a system in place whereby an  
 20 employee can report a practice that he or she  
 21 may perceive as posing a risk?  
 22 MS. PREDHAM:  
 23 A. If they consider that it's--you know, if it's  
 24 a risk, frontline staff call me all--not all  
 25 the time, but they do call me and say, you

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1 know, I think this issue is a risk. There's  
 2 also--they have professional practice reports  
 3 which are more professional practice issues.  
 4 Sometimes they overlap, sometimes they don't,  
 5 and I do believe all the professional bodies  
 6 such as--well, I know nursing has it, but I  
 7 think all the OT, social worker, and all that  
 8 have that same process.  
 9 CHAYTOR, Q.C.:  
 10 Q. But is there an actual--so if there's  
 11 something that's an occurrence or could be an  
 12 occurrence, your near misses or something that  
 13 actually happens, there's a formal process,  
 14 you fill out a form, it comes to your  
 15 department and then all these are looked at?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. All are looked at to see if you have any  
 20 trends, and we talked a little about the  
 21 importance of doing that. Is there a similar  
 22 type of form or process where an employee  
 23 could fill out if they saw something that they  
 24 think this is really getting to the point  
 25 where we think there's a patient safety issue

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1 here and we should fill out this, or have they  
 2 been told, like, the chain that they should go  
 3 through in addressing those types of issues?  
 4 MS. PREDHAM:  
 5 A. I think they would fill out an occurrence  
 6 report for that. We've seen occurrence  
 7 reports on that type of issue because they  
 8 would consider that, you know, something is  
 9 going to happen or something could happen  
 10 here.  
 11 CHAYTOR, Q.C.:  
 12 Q. And once then you receive these reports and if  
 13 you notice a trend, do you or people then  
 14 within your department have a role then to  
 15 play in terms of investigating what could be  
 16 causing the trend?  
 17 MS. PREDHAM:  
 18 A. Well, we would link with the manager or  
 19 director of that area and that would be, you  
 20 know, because we need their--you know, they're  
 21 responsible for that and we have to support  
 22 them, but we'd have to go into that area and  
 23 investigate it.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, and I take your goal to be to try and

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1 find out what could have caused it and to come  
 2 to some sort of resolution after having  
 3 identified the cause?  
 4 MS. PREDHAM:  
 5 A. Yes. Now in the literature, it's well  
 6 recognized that there's under reporting in  
 7 occurrence reporting, so one of our challenges  
 8 and one of the reasons we do so much education  
 9 is that we have to encourage staff to report,  
 10 and we've done up a--we did up a proposal in  
 11 2005 for an electronic occurrence reporting  
 12 system and we were successful in getting  
 13 funding and that's currently being implemented  
 14 now.  
 15 CHAYTOR, Q.C.:  
 16 Q. And I think when we last met for your  
 17 interview, which is almost a year ago, 11  
 18 months ago in November, you had indicated then  
 19 for electronic occurrence reporting, and it  
 20 was 1.6 million dollars -  
 21 MS. PREDHAM:  
 22 A. 1.8 million.  
 23 CHAYTOR, Q.C.:  
 24 Q. 1.8 million dollars that you received for  
 25 that.

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1 MS. PREDHAM:  
 2 A. Yeah.  
 3 CHAYTOR, Q.C.:  
 4 Q. So what stage is that at?  
 5 MS. PREDHAM:  
 6 A. That--we're in the process of the pre go-live  
 7 stage implementing that in one area to work  
 8 out the--you know, we have it all tentatively  
 9 worked out with the software. We have the  
 10 Taxonomy done, we have the training plan  
 11 already done, so we have to work it out in one  
 12 little area. I guess you could call it a  
 13 pilot, or that's what I would refer to it as,  
 14 to work out the logistics of it, and then we  
 15 move it on. The whole concept, though, behind  
 16 the proposal of what we--there was a couple of  
 17 key messages with our proposal and one was  
 18 that we were trying to use it as a tool to  
 19 encourage patient safety, to change that  
 20 culture of patient safety. So it wasn't like,  
 21 oh, here's your occurrence reporting system,  
 22 you can stop using paper now, you can use  
 23 this. It was to say this is what patient  
 24 safety is all about and this is why it's  
 25 important to do that. So the focus wasn't on

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1 the tool, the focus was on the patient safety  
 2 culture.  
 3 CHAYTOR, Q.C.:  
 4 Q. On the education of the staff to this patient  
 5 safety culture.  
 6 MS. PREDHAM:  
 7 A. Exactly.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay.  
 10 MS. PREDHAM:  
 11 A. And the other key thing is that we would have  
 12 our taxonomy, the way the occurrences are  
 13 described, it's the leverage of both British  
 14 Columbia, which also got money from Canada  
 15 Health Infoway, so, you know, it's almost to  
 16 have that pan Canadian ability to report or  
 17 compare trends and that across Canada. We've  
 18 also based it on--the World Health  
 19 Organization has come out with a draft  
 20 taxonomy, so we've used that as the  
 21 fundamental there, so if there's anything  
 22 worldwide like that, we would have the basic  
 23 structure of how the occurrences are named so  
 24 we would be able to do trending like that.  
 25 We'd have, like, all the same things.

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1 CHAYTOR, Q.C.:  
 2 Q. Okay, and so now there's no difference, I take  
 3 it, in the actual policy that's in place in  
 4 terms of occurrence reporting, but the  
 5 mechanism for reporting will now be done  
 6 electronically?  
 7 MS. PREDHAM:  
 8 A. Yes, well, the policy will have to be updated  
 9 a bit because it was an internal thing that we  
 10 put in place, but, yes, the fundamentals are  
 11 no different. If we were just going to--you  
 12 know, it would have been so easy just to get  
 13 the software, put it in, and say here you go,  
 14 this is how you report it right now because  
 15 it's technically not very difficult to do, but  
 16 the cumbersome part, the hard part, is to make  
 17 sure that people are aware of this and use it  
 18 as an opportunity to try to change the  
 19 culture.  
 20 CHAYTOR, Q.C.:  
 21 Q. So if you--if staff sees fit to fill out an  
 22 occurrence report, it's not currently in  
 23 place, I take it?  
 24 MS. PREDHAM:  
 25 A. No.

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1 CHAYTOR, Q.C.:  
 2 Q. It's soon to come on.  
 3 MS. PREDHAM:  
 4 A. Soon to come on.  
 5 CHAYTOR, Q.C.:  
 6 Q. So the process will be that they'll actually  
 7 electronically fill out the form and it goes  
 8 to you or -  
 9 MS. PREDHAM:  
 10 A. It will go to the manager and the quality  
 11 safety leader assigned to that area  
 12 simultaneously, so there won't be any lag then  
 13 in time because before we were waiting for a  
 14 piece of paper to make its way throughout the  
 15 organization. So that's a great benefit, and  
 16 the other ability is that the reporter will  
 17 have a way to get feedback on that if they so  
 18 wish because that's the other, I guess, a  
 19 hinderance to people filling out occurrence  
 20 report, if I'm filling out an occurrence  
 21 report and I send it away and I don't get that  
 22 feedback, you know, there is that--you like to  
 23 know that you're making a difference or that  
 24 there's a point of filling these things out.  
 25 So that's one thing that we really wanted in

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1 this electronic system.  
 2 CHAYTOR, Q.C.:  
 3 Q. And then so the software that you have, would  
 4 it--in terms of trying to track any kinds of  
 5 trends, would it allow you more easily to be  
 6 able to do that?  
 7 MS. PREDHAM:  
 8 A. Yes, definitely. I mean, right now to do  
 9 trending or reporting, you know, we do have  
 10 limited reporting ability on that, but it's  
 11 very cumbersome, it's not quick, it's not  
 12 easy, and if you want to do anything off the  
 13 standard, just listing of these are the ones  
 14 that you've had for this area, you have to put  
 15 it in Excel, you have to--and whatever. Just  
 16 one click of the button, the manager can do  
 17 it. So there will be set reports that the  
 18 manager would like to have that will be  
 19 available to them, so all they have to do is  
 20 this week they can go in, how is everything  
 21 going here and click a button, and there's  
 22 their information.  
 23 CHAYTOR, Q.C.:  
 24 Q. Right, so you could search key words? Like,  
 25 if you need to search "fixation" it would be

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1 there?  
 2 MS. PREDHAM:  
 3 A. You could do that.  
 4 CHAYTOR, Q.C.:  
 5 Q. If you needed to search ER/PR, it would be  
 6 there?  
 7 MS. PREDHAM:  
 8 A. It could.  
 9 CHAYTOR, Q.C.:  
 10 Q. You hope not.  
 11 MS. PREDHAM:  
 12 A. We hope not.  
 13 CHAYTOR, Q.C.:  
 14 Q. We heard recently--we heard recently there was  
 15 a review done of the labs here in St. John's  
 16 at the request of the Commission, and there  
 17 was a problem with tissue processors and the  
 18 charcoal filters hadn't been changed for six  
 19 months. Would that be an occurrence that  
 20 would be expected to require a report to be  
 21 filled out?  
 22 MS. PREDHAM:  
 23 A. It could be, but sometimes when things are  
 24 well known or gets this immediate reaction,  
 25 occurrence report doesn't get filled out. You

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1 know, usually, and I've always said it, the  
 2 biggest things that happen in our  
 3 organization, we never got an actual  
 4 occurrence report on it because everybody  
 5 knows about it immediately, and nobody stops  
 6 to say, oh, I got to let quality know and fill  
 7 out this occurrence report because we're  
 8 already involved and we're already in that  
 9 process. So, you know, it could be, but  
 10 sometimes it isn't.  
 11 CHAYTOR, Q.C.:  
 12 Q. But in terms of--so I guess two questions  
 13 arise. In terms of the--I see the importance  
 14 of the occurrence report to get the  
 15 communication to you, but what about the  
 16 importance of the report for historical  
 17 documentation so that next year if you're not  
 18 there, or the next person five years down the  
 19 road and they can search and see, well, there  
 20 was a similar situation back in 2008?  
 21 MS. PREDHAM:  
 22 A. That is a problem, and that's one of the  
 23 things that we're trying to tighten up with  
 24 this new system. The old system was so  
 25 cumbersome to search, there wasn't--you know,

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1 we didn't see the benefit of, you know, okay,  
 2 make sure now you fill an occurrence report  
 3 because then we can search for it, but now  
 4 where we have that ease and that ability it  
 5 will make it that much more important to make  
 6 sure that we do something on that line.  
 7 CHAYTOR, Q.C.:  
 8 Q. And I take it the policy itself is not  
 9 optional, that you don't have to fill out an  
 10 occurrence report if certain people already  
 11 know, the policy is "you shall fill out your  
 12 occurrence report".  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And similarly back at the beginning of August,  
 17 2005, there was an issue in terms of the  
 18 Ventana machine and the maintenance not being  
 19 carried out. At that time, do you know  
 20 whether or not there was any occurrence report  
 21 filled out about that?  
 22 MS. PREDHAM:  
 23 A. No, there was no occurrence report.  
 24 CHAYTOR, Q.C.:  
 25 Q. No occurrence report, and the recent incident

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1 in terms of the tissue processor, from what  
 2 you're saying is that was an immediate  
 3 situation, we knew about it, there was no  
 4 occurrence report then filled out?  
 5 MS. PREDHAM:  
 6 A. Well, I can't say that for sure because I -  
 7 CHAYTOR, Q.C.:  
 8 Q. You haven't seen one, I take it?  
 9 MS. PREDHAM:  
 10 A. No, I haven't been there, but I haven't seen  
 11 one, no.  
 12 CHAYTOR, Q.C.:  
 13 Q. And you're assuming that if it's not, it's  
 14 because they know you're well aware of it?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. What if any investigation have you caused to  
 19 take place as a result of the tissue processor  
 20 incident?  
 21 MS. PREDHAM:  
 22 A. Well, I haven't been at work for the past  
 23 couple of weeks, so I haven't been involved in  
 24 anything.  
 25 CHAYTOR, Q.C.:



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1 Q. What are others undertaking?  
 2 MS. PREDHAM:  
 3 A. I don't know.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, but you would anticipate that there will  
 6 be an investigation of that issue?  
 7 MS. PREDHAM:  
 8 A. Oh, yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. And you indicated that one new policy that you  
 11 saw fit to bring in was the critical  
 12 occurrence policy. Were there any other  
 13 policies initiated by you or that have come in  
 14 since you took on the risk management  
 15 function?  
 16 MS. PREDHAM:  
 17 A. Well, I mean, there's lots of policies. I  
 18 don't think that I initiated them so much.  
 19 The disclosure guidelines came in place when I  
 20 was risk manager and the consent policy for  
 21 Health Care Corporation came in effect.  
 22 CHAYTOR, Q.C.:  
 23 Q. And you would have worked on both of those, I  
 24 take it?  
 25 MS. PREDHAM:

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1 A. The consent policy came more as a package. I  
 2 did the education throughout the Health Care  
 3 Corporation on that policy, but I didn't have  
 4 much feedback on that. I was anxiously  
 5 awaiting it, but it was a large document that  
 6 was done between ethics and legal counsel.  
 7 The disclosure policy, I was more part of that  
 8 policy development. It was originally  
 9 developed, I think again by ethics, but Dr.  
 10 Williams and myself were more into finalizing  
 11 that and communicating that throughout the  
 12 organization.  
 13 CHAYTOR, Q.C.:  
 14 Q. And, Ms. Predham, what happens when a matter  
 15 is brought to your attention either through an  
 16 occurrence report, or as you say, often major  
 17 things are just verbally communicated and you  
 18 learn about it that way, what happens when a  
 19 matter is brought to your attention that  
 20 might, in your experience and knowledge in  
 21 risk management, trigger in your mind that  
 22 liability could accrue as a result of this?  
 23 MS. PREDHAM:  
 24 A. Well, once you got the internal processes set  
 25 up, then you would have to notify the insurer.

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1 CHAYTOR, Q.C.:  
 2 Q. And so if you're thinking there might be some  
 3 liability for the Health Authority then, you  
 4 notify the insurer. Is there anything else  
 5 you do, do you open up a file, do you--is  
 6 there any difference in how you handle the  
 7 matter? What do you actually do? So  
 8 something lands on your desk, you look at it  
 9 and think this is something that could result  
 10 in liability ultimately, you phone the insurer  
 11 and put the insurer on notice, and what else  
 12 do you actually do?  
 13 MS. PREDHAM:  
 14 A. Well, I guess, just for clarification, when  
 15 something comes there, that's not the primary  
 16 focus, the liability. The primary focus would  
 17 be that there was a risk or a problem here  
 18 that needs to be investigated. So the first  
 19 contact, if it hasn't been from the program  
 20 director or clinical chief, then is to get the  
 21 program director and clinical chief involved.  
 22 At that point, you know, you have to get the  
 23 key players together to get a plan in place  
 24 and that's your first step. So depending on  
 25 the issue, it depends on who you get together.

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1 It may only be the program director and  
 2 clinical chief, but it may be depending on  
 3 that you're going to need some expert advice  
 4 right from the beginning. If it's an  
 5 infection control issue, then you're going to  
 6 need the medical director of infection  
 7 control, your manager of infection control,  
 8 around the table as well because you're going  
 9 to need their feedback to guide you as you go  
 10 through this. Depending on the issue, if it's  
 11 a certain subspecialty area, you would need to  
 12 have a division chief or the manager of that  
 13 area there to give you that extra information.  
 14 So the first session--the first meeting would  
 15 be kind of to set out the plan, who needs to  
 16 be involved, and then it's how are you going  
 17 to investigate this, what do you need to do,  
 18 and every issue like that changes a bit. You  
 19 know, to come up with how you're going to  
 20 investigate it, you really need to understand  
 21 what it is you're talking about and then come  
 22 up with a plan on how to investigate it, and  
 23 for every one that we've done, I'm sure  
 24 they've all been slightly different, depending  
 25 on who the group is that we get together and

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1 how often we get together. If there is some  
 2 kind of potential, you know, if it's a patient  
 3 complaint and they're very upset, you'd have  
 4 to involve communications. You had to  
 5 determine who's going to be the liaison with  
 6 the patient or the family. So all those  
 7 things had to be determined.

8 CHAYTOR, Q.C.:

9 Q. Yes, and I'm just thinking more from your  
 10 point of view and, I guess, your determination  
 11 in your own mind or your own assessment as to  
 12 whether or not liability, this may be  
 13 something for which the authority is held  
 14 liable, or potential liability, that could  
 15 happen when you--when the reports lands on  
 16 your desk, that could happen, you may need to  
 17 investigate, have those meetings that you're  
 18 referring to, get your team in place, carry  
 19 out some other investigations, but once you  
 20 arrive at that point, I'm just wondering if  
 21 there's any difference in how you, yourself,  
 22 go about handling the situation from that  
 23 point onwards? Once you've now made the  
 24 determination, well, this is the situation,  
 25 I've had to pick up the phone or e-mail the

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1 insurer and put them on notice, is there any  
 2 difference in how you would then handle the  
 3 situation internally?

4 MS. PREDHAM:

5 A. No, because--well, you have to consider what  
 6 the insurer needs because you've notified them  
 7 and you're carrying on with your  
 8 investigation. Sometimes the insurance  
 9 adjuster would like to take statements from  
 10 the staff and sometimes that can wait and you  
 11 can talk to the staff at the same time and get  
 12 your information at the same time just because  
 13 you don't want to put them through it twice,  
 14 but more often than not you've already talked  
 15 to the staff involved and gotten the  
 16 information and then they have to sit down  
 17 with the insurance adjuster. So the insurance  
 18 adjuster needs certain pieces of information  
 19 and they need to do certain things, but, you  
 20 know, you have to do your own thing as well.

21 CHAYTOR, Q.C.:

22 Q. And in terms of opening up a file, do you open  
 23 up a file for every occurrence that's reported  
 24 to you or to your department?

25 MS. PREDHAM:

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1 A. Not every occurrence, but every occurrence  
 2 that requires, you know, a bit of feedback  
 3 beyond a piece of paper, beyond a follow up  
 4 phone call or anything. So if it's beyond one  
 5 or two pieces of paper that could be stapled  
 6 to the occurrence report, you would open up a  
 7 file.

8 CHAYTOR, Q.C.:

9 Q. Okay. So I would take it something such as  
 10 the ER/PR issue, for example, you'd open up a  
 11 file?

12 MS. PREDHAM:

13 A. Yes, certainly.

14 CHAYTOR, Q.C.:

15 Q. Several files.

16 MS. PREDHAM:

17 A. Several, yeah, a couple of boxes.

18 CHAYTOR, Q.C.:

19 Q. And I take it that in terms of opening up that  
 20 file and how you--and the type of file that  
 21 you open up, does that differ in terms of  
 22 whether or not it's a situation for which  
 23 there may be potential liability?

24 MS. PREDHAM:

25 A. No, there's no difference at that point. The

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1 only time there's a different file as such is  
 2 if we get a Statement of Claim. So at that  
 3 point--and my goal, being involved in risk  
 4 management, is that I don't want to get a  
 5 Statement of Claim without knowing about it in  
 6 the first place. That does happen, but I  
 7 would like to think that--you know, the  
 8 majority of them we do have some knowledge  
 9 about that and investigated at that certain  
 10 level. So when we do get either a Statement  
 11 of Claim or a letter from a lawyer advising us  
 12 to notify our insurer, then that's when they  
 13 go into like a separate area and they're  
 14 handled a bit differently because then you've  
 15 got, you know, more focused liaison with legal  
 16 counsel and the insurer.

17 CHAYTOR, Q.C.:

18 Q. Okay. So the trigger for that happening and  
 19 things being handled somewhat differently is  
 20 not necessarily when you make the assessment  
 21 there might potential liability and you've  
 22 contacted the insurer, it's when you actually  
 23 receive either a Statement of Claim or  
 24 notification from a lawyer that they're  
 25 involved?

1 MS. PREDHAM:

2 A. Yes.

3 CHAYTOR, Q.C.:

4 Q. And so then what -

5 MS. PREDHAM:

6 A. That mightn't--just to clarify, that mightn't  
7 change anything I'm doing. It's just the fact  
8 that things get a little bit more formal then,  
9 you know, so that there's notification, they  
10 have to get that within ten days, there has to  
11 be--you know, so we keep that in a separate  
12 file and, you know.

13 CHAYTOR, Q.C.:

14 Q. Okay, so the legal process itself, getting the  
15 Defense filed within the appropriate time  
16 period. I'm just wondering what else, what  
17 else changes in terms of how the matter is  
18 handled once you are notified that you, in  
19 fact--legal counsel is engaged basically, what  
20 happens?

21 MS. PREDHAM:

22 A. Well, it's--I mean, there's not a lot that  
23 changes internally, but it's that you have to  
24 be aware that there is lawyers involved and  
25 you have to take direction, I guess, anything

1 MS. PREDHAM:

2 A. Not really, other than they're looking for  
3 specific things. Well, you know, you'd have  
4 to keep them up to date, they're looking for  
5 certain things. They may have a different  
6 perspective on that. You know, they might be  
7 more concerned about a different aspect on it  
8 that we're not directly concerned about, or  
9 that we feel is handled. Now that may have an  
10 influence on--you know, it may be something we  
11 never thought of, but, no, usually it's, you  
12 know, we just have to follow that process  
13 along with them.

14 CHAYTOR, Q.C.:

15 Q. And what's the importance of keeping the  
16 lawyers handling the case informed, what's the  
17 importance of doing that?

18 MS. PREDHAM:

19 A. Well, you don't want to undermine your  
20 insurance coverage. I guess that's the key  
21 thing, so you have to make sure that they're  
22 aware and in order to provide our defense,  
23 part of our policy or agreement with our  
24 insurers is that we notify them of all  
25 potential claims and keep them aware of that

1 that's going to influence or impact on their  
2 case, they had to be made aware of, you know,  
3 anything, new information, and they also are  
4 looking for certain things in--you know, in  
5 their--more requests will come in for me, you  
6 know, do you have a policy on this, or do you  
7 have--you know, that kind of--that kind of  
8 thing.

9 CHAYTOR, Q.C.:

10 Q. Okay, so then you--and when you say the  
11 lawyers who are handling the case, I take it  
12 you mean the lawyers who are handling it on  
13 behalf of Eastern Health?

14 MS. PREDHAM:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. So then you keep them in the loop as to what's  
18 happening?

19 MS. PREDHAM:

20 A. Yes.

21 CHAYTOR, Q.C.:

22 Q. And you--in terms of them yourself and your  
23 role in taking direction on the handling of a  
24 matter, does that change once legal counsel  
25 have been engaged?

1 information. So, you know, you wouldn't want  
2 to keep them in the dark about something if  
3 they're going ahead because they're going on  
4 their own way down that legal route, and I  
5 don't know everything that they're doing as  
6 they go along that, so I wouldn't want to have  
7 some information that they've gone down a  
8 certain way and unaware that this is what's  
9 happening over here.

10 CHAYTOR, Q.C.:

11 Q. Or take a particular course of action that may  
12 ultimately end up undermining your insurance  
13 coverage?

14 MS. PREDHAM:

15 A. Well, exactly, because that's--you know, you  
16 wouldn't do that for your house or your car  
17 insurance either.

18 THE COMMISSIONER:

19 Q. I just didn't quite understand what it is you  
20 were saying when you said that you didn't want  
21 to undermine the insurance company--the  
22 insurance coverage, sorry?

23 MS. PREDHAM:

24 A. Okay, the--I guess just that fundamental, that  
25 you don't want to, you know, do something in

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1 which you're inadvertently admitting to  
 2 liability unbeknownst to--you know, you're  
 3 doing some action that could be perceived that  
 4 you're admitting to liability here. I guess  
 5 that's the ultimate thing, you don't want to  
 6 do something that, you know, you're going to  
 7 admit--to be held that you're going to admit  
 8 to something and you're not really.  
 9 THE COMMISSIONER:  
 10 Q. Okay.  
 11 MS. PREDHAM:  
 12 A. I guess it's just--you know, if you get into a  
 13 car accident and on that little plastic thing  
 14 that's in your glove box and it says, you  
 15 know, do not admit blame, that's that type of  
 16 thing, so you want to make sure that any  
 17 actions that the organization is doing, that  
 18 you're not going to admit blame inadvertently  
 19 when you don't really mean to.  
 20 CHAYTOR, Q.C.:  
 21 Q. And would you also not want to do anything  
 22 which could potentially create a cause of  
 23 action where one might not otherwise exist?  
 24 MS. PREDHAM:  
 25 A. Oh, definitely.

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1 CHAYTOR, Q.C.:  
 2 Q. Because that might undermine your insurance  
 3 coverage as well?  
 4 MS. PREDHAM:  
 5 A. Yes, yeah.  
 6 CHAYTOR, Q.C.:  
 7 Q. And when I started asking you about this and  
 8 how things differ once legal counsel are  
 9 engaged, you started to say in terms of you  
 10 have to take direction, and I'm just  
 11 wondering, you have to take direction from  
 12 whom at that point in time?  
 13 MS. PREDHAM:  
 14 A. Well, it depends. It could be the insurance  
 15 adjuster. Certain claims are handled at that  
 16 level entirely. It could be legal counsel as  
 17 well. They could pass it off to legal  
 18 counsel. It all depends on the situation.  
 19 CHAYTOR, Q.C.:  
 20 Q. And if legal counsel or the insurance company  
 21 or their representatives were to indicate to  
 22 you that if you take a certain course of  
 23 action, you could potentially undermine your  
 24 insurance coverage for a given claim, I take  
 25 it that would be fairly significant advice for

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1 you then to take?  
 2 MS. PREDHAM:  
 3 A. Well, I'd certainly have to pass that on very  
 4 quickly and -  
 5 CHAYTOR, Q.C.:  
 6 Q. To others.  
 7 MS. PREDHAM:  
 8 A. Make sure that people are aware of that  
 9 because that's--you know, that's something  
 10 that would require a decision, you know,  
 11 higher than me.  
 12 CHAYTOR, Q.C.:  
 13 Q. And that could have significant influence then  
 14 on the course of action that you choose to  
 15 take?  
 16 MS. PREDHAM:  
 17 A. Yes. There have been circumstances, not very  
 18 often, where--you know, I can think of one in  
 19 particular in which someone wanted to be  
 20 reimbursed for cost that we totally agreed  
 21 with, and it was taking myself and Dr.  
 22 Williams an exceedingly long period of time to  
 23 get them to agree to that, the insurance  
 24 company to agree to that, and actually I was  
 25 to the point where I was almost embarrassed to

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1 pick up the phone from that family any more,  
 2 and Dr. Williams agreed to reimburse that  
 3 family for that cost, you know, and we'd have  
 4 to live with whatever the insurance company--  
 5 however mad they got at us for that. So there  
 6 are circumstances in which we've done that,  
 7 but that's not taken very lightly.  
 8 CHAYTOR, Q.C.:  
 9 Q. And the insurance company's concern would be  
 10 that you would confirm the cause of action by  
 11 making any payment?  
 12 MS. PREDHAM:  
 13 A. Yeah, I guess that's the way you would put it.  
 14 CHAYTOR, Q.C.:  
 15 Q. In terms of the ER/PR issue, when did you open  
 16 up your file?  
 17 MS. PREDHAM:  
 18 A. I think it was July 12th I actually got the  
 19 details of it and it was then, that's what I  
 20 opened up my file and I think that's also when  
 21 I notified our insurance adjuster.  
 22 CHAYTOR, Q.C.:  
 23 Q. And I'm sorry, when was that?  
 24 MS. PREDHAM:  
 25 A. July 12th.

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1 CHAYTOR, Q.C.:

2 Q. July 12th.

3 THE COMMISSIONER:

4 Q. What did you say, you notified whom?

5 MS. PREDHAM:

6 A. I notified our insurance adjustor.

7 THE COMMISSIONER:

8 Q. The adjustor.

9 CHAYTOR, Q.C.:

10 Q. And in this context, that would be whom?

11 MS. PREDHAM:

12 A. That was Ray Walsh at the time.

13 CHAYTOR, Q.C.:

14 Q. And what happened on July 12th to make you

15 make the decision that I need to open up a

16 file and I need to phone Mr. Walsh?

17 MS. PREDHAM:

18 A. Well I had a meeting with Dr. Williams the

19 beginning of June, I can't remember the date

20 now, but it was about other issues and at that

21 meeting, he said there's a problem in the lab

22 and he gave me a slight overview of it and he

23 gave me a copy of a letter that Dr. Cook had

24 given him. In that, Dr. Cook had said that he

25 didn't know if it was a big issue or not at

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1 that time and, but if it was, he was going to

2 have to get our department involved. So Dr.

3 Williams was giving me a heads up on it and

4 said this could be nothing or this could be

5 something big. And I asked him what he wanted

6 me to do at this time and he said, nothing

7 right now, I'll let you know what comes out,

8 they're further investigating and I'll let you

9 know at that time.

10 CHAYTOR, Q.C.:

11 Q. Do you recall when in June that was?

12 MS. PREDHAM:

13 A. I'm thinking June 10th, but I'd have to look

14 at an actual--it was on a Thursday, probably

15 the first or second week of June, yes.

16 CHAYTOR, Q.C.:

17 Q. Yes, okay. Sorry, okay, you can go ahead.

18 MS. PREDHAM:

19 A. So June 12th I had a meeting--Dr. Williams

20 asked me to come over to a meeting with

21 himself, Mr. Gulliver and Dr. Cook, and that's

22 when I got the details of what was going on.

23 CHAYTOR, Q.C.:

24 Q. Okay, so was it June 12th then that you -

25 MS. PREDHAM:

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1 A. July 12th, sorry, I said June, didn't I.

2 CHAYTOR, Q.C.:

3 Q. July 12th, okay, so between June 10th and July

4 12th, things were quiet on your end with

5 respect to this issue?

6 MS. PREDHAM:

7 A. Yes, very quiet.

8 CHAYTOR, Q.C.:

9 Q. So you heard nothing after that initial

10 meeting with Dr. Williams when he gave you a

11 little bit of a heads up, but it may be

12 nothing or it could be something. And then

13 July 12th is when you have your meeting.

14 MS. PREDHAM:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. And coming out of that meeting then is when

18 you opened your file and phoned Mr. Walsh?

19 MS. PREDHAM:

20 A. Yes.

21 CHAYTOR, Q.C.:

22 Q. Okay, and I'll take you to that in a little

23 while. I just want to go back to a moment

24 then in terms of what you do in the general

25 and broader sense, in terms of your quality

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1 and risk management. And I'm wondering

2 whether or not the quality department, and

3 forgive me if that's not the actual term, but

4 -

5 MS. PREDHAM:

6 A. That's okay, we've had so many names over the

7 years, quality is just as good as any.

8 CHAYTOR, Q.C.:

9 Q. Yes. I'm wondering what your department does

10 to ensure--what it does, if anything, to ensure

11 that the various programs have in place an

12 appropriate quality assurance program?

13 MS. PREDHAM:

14 A. We can't--well the program directors are

15 responsible for--the program directors, the

16 clinical chiefs, the department directors are

17 responsible for quality and risk management in

18 their areas. They report into a portfolio

19 committee currently in Eastern Health, which

20 reports into Regional Quality Council, and

21 they have to report on a regular basis. Each

22 of the quality safety leaders are linked with

23 the leadership and are in close contact with

24 them. So they would be aware of the type of

25 thing that they're monitoring, the type of

Page 85

1 occurrences that they have and through that,  
 2 would have a comfort level with what type of  
 3 quality activities that they have on that  
 4 area.  
 5 CHAYTOR, Q.C.:  
 6 Q. That's the current process?  
 7 MS. PREDHAM:  
 8 A. Which is much the same as it was in the old  
 9 Health Care Corporation.  
 10 CHAYTOR, Q.C.:  
 11 Q. So the program director and the clinical chief  
 12 would be responsible for making sure that  
 13 there's an appropriate quality assurance  
 14 program for their particular program and they  
 15 would report up to which committee, up to,  
 16 say, 2005?  
 17 MS. PREDHAM:  
 18 A. Up to 2005, it would be corporate quality  
 19 initiatives and that was the corporate wide  
 20 quality committee.  
 21 CHAYTOR, Q.C.:  
 22 Q. And so if there were any short comings in a  
 23 Quality Assurance Program for any given area,  
 24 you would expect the Corporate Quality  
 25 Initiatives Committee to be made aware of it?

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1 MS. PREDHAM:  
 2 A. Yes, they would have to report annually on  
 3 that. There was a structure that they would  
 4 have to report to use to do that, and so with  
 5 their indicators, you could see that they  
 6 would have a broad base there and you'd have--  
 7 there was a format to develop your indicators,  
 8 so there were eight dimensions of quality and  
 9 they would like to have indicators in each of  
 10 those dimensions and they should be reflected  
 11 in the documents that come up in Regional  
 12 Quality Council.  
 13 CHAYTOR, Q.C.:  
 14 Q. And are you aware as to whether or not any  
 15 issue ever got brought to the Corporate  
 16 Quality Initiatives Program regarding any  
 17 inadequacies in the Laboratory Medicine  
 18 Program, Quality Assurance Program?  
 19 MS. PREDHAM:  
 20 A. No.  
 21 THE COMMISSIONER:  
 22 Q. Are you aware or no, there was none.  
 23 MS. PREDHAM:  
 24 A. No, I wasn't aware.  
 25 CHAYTOR, Q.C.:

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1 Q. You're not aware if anything got brought  
 2 forward to that committee?  
 3 MS. PREDHAM:  
 4 A. No.  
 5 CHAYTOR, Q.C.:  
 6 Q. And so, for example, we've heard here that the  
 7 IHC component of the pathology lab did not  
 8 have any external proficiency testing in place  
 9 in the relevant time period, that's not  
 10 something that was ever brought to the  
 11 attention of the Corporate Quality Initiatives  
 12 Program?  
 13 MS. PREDHAM:  
 14 A. No.  
 15 CHAYTOR, Q.C.:  
 16 Q. And is that something that was ever brought to  
 17 your attention or your department's attention?  
 18 MS. PREDHAM:  
 19 A. No, until ER/PR came up, I never knew what  
 20 immunohistochemistry was or that there was a  
 21 portion of the pathology lab was dedicated to  
 22 that, so this was all new, a new area.  
 23 CHAYTOR, Q.C.:  
 24 Q. So July 12th, you had a steep learning curve  
 25 ahead of you.

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1 MS. PREDHAM:  
 2 A. Very steep.  
 3 CHAYTOR, Q.C.:  
 4 Q. Well you're in good company. And in terms  
 5 then, what else your department does in the  
 6 overall quality aspect, a little bit more on  
 7 the quality aspect, would you be involved at  
 8 all, for example, in performing any audits?  
 9 MS. PREDHAM:  
 10 A. We have from time to time, we're more involved  
 11 in developing the audits or assisting the  
 12 programs in developing the audits. It depends  
 13 on what the audit is for and it's usually  
 14 initiated on request of the area. There was a  
 15 documentation committee, there may still be,  
 16 but I'm not on that, but as part of that, we  
 17 were involved in developing and documentation  
 18 audit and we would assist areas in doing the  
 19 analysis of the audits when they get them done  
 20 for that matter. Depending on an issue, you  
 21 know, in certain areas you would have specific  
 22 issues that they would like to take a period  
 23 of time to audit and look at that and focus in  
 24 on that area for a period of time. And we've  
 25 done that over a period of time as well.

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1 CHAYTOR, Q.C.:

2 Q. Okay, and in this particular case, we've heard

3 of some short comings in the Laboratory

4 Medicine Program in terms of documentation,

5 for example documentation to verify that

6 routine maintenance is being carried out on

7 equipment, documentation in terms of standard

8 operating procedures, were those things ever

9 brought to the attention of the Quality

10 Department?

11 MS. PREDHAM:

12 A. Not that I'm aware of, no.

13 CHAYTOR, Q.C.:

14 Q. And when did you first become aware of those

15 issues?

16 MS. PREDHAM:

17 A. When I went over in August to just start that

18 quality review.

19 CHAYTOR, Q.C.:

20 Q. Okay, and we'll come to that. And do you know

21 whether or not those issues were ever brought

22 to the attention of the Corporate Quality

23 Initiatives Department?

24 MS. PREDHAM:

25 A. I never sat on Corporate QI until I became

Page 90

1 acting director, but I'm not aware of, I don't

2 think so.

3 CHAYTOR, Q.C.:

4 Q. And that would have been in January, 2004 that

5 you became the acting director.

6 MS. PREDHAM:

7 A. Yes.

8 CHAYTOR, Q.C.:

9 Q. So in terms of any function that your

10 department would have in carrying out

11 documentation audits, it would, should that

12 happen, I take it look for things, such as is

13 your daily, monthly maintenance being carried

14 out? What documentation do you have in place

15 in terms of standard operating procedures,

16 those are the kinds of things that you would

17 be looking at?

18 MS. PREDHAM:

19 A. Well, you'd like to do that because if staff

20 had to document things, you want them to make

21 sure that they're documenting something that's

22 meaningful. So if you have staff who are

23 spending, you know, have tick off lists of two

24 sides of it, you want to make sure that it's

25 meaningful and you also want it to reflect the

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1 practice that they're doing. So we've been

2 involved in documentation issues where, you

3 know, there's a tick off list which the staff

4 have been doing for ever and a day, but it no

5 longer effectively reflects what they're doing

6 and no longer effectively documents what

7 they're actually doing. It's just that this

8 has been in practice forever and nobody really

9 thought about it, it's just something we

10 always did. So we've been involved in that

11 kind of thing. Also in areas where you want

12 to cut down on the amount of documentation

13 that they're doing, that they're spending a

14 lot of time or documentation is not getting

15 done because it's so cumbersome, but in fact,

16 it's a lot of extra stuff, you don't really

17 need to get--you're not really documenting the

18 important things. So situations where we have

19 been involved in that, that's the type of

20 thing that we've been looking at.

21 CHAYTOR, Q.C.:

22 Q. Okay, and in terms of what each department

23 would be acquired to submit to the Quality

24 Initiatives Department and, of course, we've

25 talked about occurrence reports. Are they

Page 92

1 also required to submit annual reports to the

2 Quality Initiatives Department?

3 MS. PREDHAM:

4 A. Not to us because we're only a support

5 department, so they are responsible for

6 quality and risk management, that's the way

7 the framework or the structure has, so they

8 submit those to Corporate QI, that's Corporate

9 Quality Initiatives, as well as their VP or

10 whoever they report to would have to get a

11 copy of that. So that's that line

12 responsibility, as well as the quality

13 committee structure, so we could be involved

14 in the development of their quality program

15 and that changed, of course, over time. I

16 mean if you're linked with a program director

17 and back in '97, you're over meeting and

18 coming up with the way their quality report is

19 going to be, by the time 2004 rolls around and

20 it's you and the same quality director, you're

21 not involved--like, they're well on their way

22 of doing that on their own.

23 CHAYTOR, Q.C.:

24 Q. Okay, so we've seen quality initiative reports

25 here coming out of the Laboratory Medicine

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1 Program, so those go directly to the Corporate  
 2 Quality Initiatives Committee?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. That's where those go.  
 7 MS. PREDHAM:  
 8 A. Right.  
 9 CHAYTOR, Q.C.:  
 10 Q. And your staff, the quality facilitators may  
 11 be involved in helping them come up with the  
 12 annual report and the content for the report,  
 13 but you don't actually get a copy of the  
 14 report?  
 15 MS. PREDHAM:  
 16 A. No. We may, now it depends on, you know, the  
 17 program director may send it to the  
 18 facilitator, but I guess that just depends on  
 19 the individuals involved.  
 20 CHAYTOR, Q.C.:  
 21 Q. And does your department, the Quality  
 22 Department, have any role in ensuring  
 23 performance evaluations are carried out on the  
 24 staff in the various programs?  
 25 MS. PREDHAM:

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1 A. Not directly, we do have a role with  
 2 accreditation and so that is always an issue  
 3 with accreditation, so we'd have a role from  
 4 that aspect of it and also as an indicator,  
 5 you know, if the percent--the number of people  
 6 that are doing occurrence reports who have  
 7 actually got it done, that would be one of the  
 8 indicators that we would look at. But Human  
 9 Resources would take more of a direct role on  
 10 ensuring that.  
 11 CHAYTOR, Q.C.:  
 12 Q. And if it were, though, to come to the  
 13 attention of your department that performance  
 14 evaluations were not being carried out on a  
 15 regular basis, is that something that your  
 16 department would be interested in addressing?  
 17 MS. PREDHAM:  
 18 A. We'd be interested in it, but I don't think  
 19 that we've got that--there was a lot of effort  
 20 put into that from Human Resources, so I don't  
 21 think we would add anything to that, as such.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay. And I may have asked you this last day,  
 24 but your current location, the Quality  
 25 Initiatives Department, where are you

Page 95

1 currently located?  
 2 MS. PREDHAM:  
 3 A. The St. John's, well, the bulk of our  
 4 department is at Southcott Hall, down by the  
 5 Miller Centre and we have quality safety  
 6 leaders located at Cordage Place, at Hoyles  
 7 Home, Carbonear, Clarenville.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and in terms of having quality and  
 10 safety -  
 11 MS. PREDHAM:  
 12 A. Leaders.  
 13 CHAYTOR, Q.C.:  
 14 Q. Leaders, are there -  
 15 MS. PREDHAM:  
 16 A. They were the quality facilitators.  
 17 CHAYTOR, Q.C.:  
 18 Q. They're the quality facilitators.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, so there's one at the Hoyles Home and is  
 23 that person then for all of the long-term care  
 24 facilities?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And the person in Carbonear covers what area?  
 4 MS. PREDHAM:  
 5 A. Rural Avalon.  
 6 CHAYTOR, Q.C.:  
 7 Q. Rural Avalon. And where is the St. John's  
 8 person located, in your offices or Cordage  
 9 Place, is it?  
 10 MS. PREDHAM:  
 11 A. We have two now in St. John's that are located  
 12 at Southcott Hall for the St. John's  
 13 hospitals, well one is for St. John's  
 14 hospitals, one is for regional services.  
 15 CHAYTOR, Q.C.:  
 16 Q. So there's no personnel from your department  
 17 located directly within either St. Clare's or  
 18 the Health Sciences Centre?  
 19 MS. PREDHAM:  
 20 A. No, anyone from St. John's hospitals is  
 21 located with us at Southcott Hall.  
 22 CHAYTOR, Q.C.:  
 23 Q. At Southcott Hall. And when did you move to  
 24 Southcott Hall?  
 25 MS. PREDHAM:



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1 A. In January 2004.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay.  
 4 THE COMMISSIONER:  
 5 Q. You said that your department was only a  
 6 support department?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 THE COMMISSIONER:  
 10 Q. So I just sort of want to be clear I  
 11 understand roles and where there are  
 12 obligations, so is the reporting of incidents,  
 13 which you've described earlier in the morning,  
 14 and--let's start with the reporting. Is that  
 15 the sole function where somebody has an  
 16 obligation to report to you, as opposed to  
 17 somebody going to your department to say in  
 18 carrying out this role that we have, we would  
 19 like your assistance?  
 20 MS. PREDHAM:  
 21 A. Just so I get clear what you're asking, if a  
 22 frontline nurse fills out an occurrence  
 23 report, that goes to their manager who has to  
 24 investigate that.  
 25 THE COMMISSIONER:

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1 Q. Uh-hm.  
 2 MS. PREDHAM:  
 3 A. After that investigation is done, it comes to  
 4 our department then to review it, to see if  
 5 there's any further investigation from our  
 6 perspective or if there needs to be any  
 7 assistance.  
 8 THE COMMISSIONER:  
 9 Q. Yes, but that's a clear line that nobody can--  
 10 as I understand what's been said, but perhaps  
 11 I'm incorrect, there would be--if, once an  
 12 occurrence report is filled out, it should get  
 13 to you.  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 THE COMMISSIONER:  
 17 Q. At some point.  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 THE COMMISSIONER:  
 21 Q. But what I'm really wanting to know is whether  
 22 or not within a department that has its own  
 23 quality person, with its own quality  
 24 initiatives, have they any obligatory contact  
 25 with you or is it just if within that

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1 department they feel they want your assistance  
 2 because they're developing a new approach or  
 3 just because they want somebody to review  
 4 their procedures or for any other of a myriad  
 5 of reasons, is that the kind of circumstances  
 6 they come to you or is there a role for your  
 7 department to walk in and say, okay, do you  
 8 have quality initiatives and let me have a  
 9 look?  
 10 MS. PREDHAM:  
 11 A. For a person in the department being a quality  
 12 person in the department, that's a new  
 13 structure for us, so I guess we're working  
 14 that out.  
 15 THE COMMISSIONER:  
 16 Q. Okay.  
 17 MS. PREDHAM:  
 18 A. They would be responsible to ensure that the  
 19 quality policies, procedures, the frameworks  
 20 are all in place there and certainly they can  
 21 ask our assistance, and have. But if there's  
 22 any occurrences or anything, we have to take  
 23 the responsibility of making sure that the  
 24 follow up was done and that it's there. We've  
 25 never gone in, I guess no one in quality as a

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1 big stick, you know, for want of a better  
 2 term. We have, diplomacy, I guess is our  
 3 biggest tool and we have to go in there and  
 4 work with staff to do that, so we're not an  
 5 auditing type of department.  
 6 THE COMMISSIONER:  
 7 Q. Uh-hm.  
 8 MS. PREDHAM:  
 9 A. Once we get in there to look at something, we  
 10 can say, well is that really showing you what  
 11 you need to look at? Do you have this? Where  
 12 is that, well you really need -  
 13 THE COMMISSIONER:  
 14 Q. But in the reporting procedure at the end of  
 15 the day, as I understand your evidence a  
 16 little earlier, it goes to a committee, not to  
 17 you.  
 18 MS. PREDHAM:  
 19 A. No, yes.  
 20 THE COMMISSIONER:  
 21 Q. So it's only that occasionally you might call  
 22 up somebody and wander in, in your own  
 23 diplomatic way that you get to put your  
 24 fingers into a department, as it were.  
 25 MS. PREDHAM:

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1 A. Well it's linkages between the quality  
 2 facilitator or the quality person linked with  
 3 that department and the leadership team. And  
 4 those, the quality facilitators in our  
 5 structure that we have now, are on the  
 6 portfolio committees where all the program  
 7 directors and where those reports come in. So  
 8 they have a more, you know, they're involved  
 9 in that more than they were with the Health  
 10 Care Corporation on that level.  
 11 THE COMMISSIONER:  
 12 Q. Okay.  
 13 MS. PREDHAM:  
 14 A. Does that answer your question?  
 15 THE COMMISSIONER:  
 16 Q. Well, it does in the sense that I now know  
 17 where the information goes, but I'm still  
 18 understanding that in fact within your  
 19 department the only flow of information that  
 20 is required is the incident reports.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 THE COMMISSIONER:  
 24 Q. Okay, thank you. Oh, while I'm at it, what  
 25 about staff safety, is that covered in an

Page 102

1 incident report or does that go through  
 2 another system?  
 3 MS. PREDHAM:  
 4 A. That goes through Occupational Health &  
 5 Safety. There are times when an occurrence  
 6 report and an employee incident report will be  
 7 completed for the same issue.  
 8 THE COMMISSIONER:  
 9 Q. Yes, uh-hm.  
 10 MS. PREDHAM:  
 11 A. But that goes through Human Resources.  
 12 THE COMMISSIONER:  
 13 Q. So, for example, if we're dealing with a  
 14 laboratory where, as I understand it there may  
 15 be dangerous material, that becomes an issue  
 16 that would probably be handled, not by you  
 17 because it's unlikely that a patient would  
 18 necessarily be involved, et cetera, et cetera.  
 19 MS. PREDHAM:  
 20 A. Well if there was a spill, you know, that was  
 21 not handled correctly, that, you know, should  
 22 be filled out on two forms, whether or not it  
 23 is or not, you know -  
 24 THE COMMISSIONER:  
 25 Q. So it's a question of whether or not it falls

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1 within the definition of an occurrence, but it  
 2 may not, it may be handled entire on the  
 3 Occupational Health & Safety side.  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 THE COMMISSIONER:  
 7 Q. All right, thank you.  
 8 CHAYTOR, Q.C.:  
 9 Q. Ms. Predham, the failure mode affects  
 10 analysis, I understood your description of  
 11 that is to evaluate any new system or testing  
 12 coming into effect. Is there any similar  
 13 process in place to evaluate your current or  
 14 existing systems and processes?  
 15 MS. PREDHAM:  
 16 A. Well that would be our process improvement  
 17 team, that's what we've done all along.  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, so that's the type of issue that we  
 20 discussed earlier as to what -  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And they could do that on a proactive basis,  
 25 as well as after an incident?

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1 MS. PREDHAM:  
 2 A. Well, yes, you know, but I guess the failure  
 3 mode affects analysis is for an anticipated  
 4 program or something because you want to have  
 5 that fully upfront before you have it running,  
 6 before any problems occur after it's set up.  
 7 But if you had, if there were concerns that  
 8 weren't fill out occurrences, you could put in  
 9 a process improvement team to try and work  
 10 that out, or it may be a situation where, you  
 11 know, you've got information from another  
 12 board or from somewhere else and look, they  
 13 had this problem, let's look at our system and  
 14 see what we have here. So you could do a  
 15 process improvement team that way.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, and I guess what I'm wondering is any  
 18 other proactive aspects to Eastern Health's  
 19 quality and risk management practices.  
 20 MS. PREDHAM:  
 21 A. Other than the staff education and trying to  
 22 utilize occurrence reporting, you know, that  
 23 whole near miss concept that you're getting it  
 24 before it actually something happens. It's  
 25 very difficult with the resources that we've

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1 had to be proactive as much as you would like  
 2 to be, you know, you don't want anything to  
 3 ever happen. I mean, things are going to  
 4 happen, but you want to be able to deal with  
 5 it beforehand and you certainly don't want to  
 6 ever get in a situation where you investigate  
 7 it with staff and staff are telling you that,  
 8 geez, this is only a matter of time this  
 9 happened, that's your worse case scenario, you  
 10 don't want ever to have that happen.

11 CHAYTOR, Q.C.:

12 Q. Okay, and who is responsible for ensuring that  
 13 appropriate policies and procedures are in  
 14 place for each program? Is that also the  
 15 leadership team of that program?

16 MS. PREDHAM:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. So that's the clinical chief and the program  
 20 director.

21 MS. PREDHAM:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. And making sure that they are updated when  
 25 required, that falls within their

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1 responsibility.

2 MS. PREDHAM:

3 A. Yes.

4 CHAYTOR, Q.C.:

5 Q. And does your program do anything to monitor  
 6 that?

7 MS. PREDHAM:

8 A. No.

9 CHAYTOR, Q.C.:

10 Q. And is your program involved at all in policy  
 11 development for the various programs?

12 MS. PREDHAM:

13 A. Not for the various programs, up to 2006, we  
 14 were responsible for the Admin Policy Manual  
 15 and co-ordinating the development of the  
 16 policies in that.

17 CHAYTOR, Q.C.:

18 Q. And the admin policy development would have  
 19 included the institution-wide disclosure  
 20 policy?

21 MS. PREDHAM:

22 A. Yes.

23 THE COMMISSIONER:

24 Q. Who is responsible for that generally?

25 MS. PREDHAM:

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1 A. That's in Policy and Research, I think that's  
 2 the name of the department now, I think.

3 CHAYTOR, Q.C.:

4 Q. The example that you gave in terms of when I  
 5 was asking you about taking direction from the  
 6 insurer's representatives from time to time,  
 7 in terms of not wanting to undermine any--your  
 8 insurance coverage and you gave the example of  
 9 Dr. Williams, this family was waiting to have,  
 10 to be reimbursed for travel expenses and I  
 11 understand from what you're saying, you took  
 12 the chance and paid them, this family had  
 13 waited long enough. In doing that, and paying  
 14 out in light of any caution by the insurer, I  
 15 take it it would depend on what value or  
 16 quantum the claim ultimately might be. For  
 17 example, if that were a multi-million dollar  
 18 potential liability, you'd probably be more  
 19 prone to take your direction from the insurer?

20 MS. PREDHAM:

21 A. Yes. And that was, you know, a very unusual  
 22 circumstance as well.

23 CHAYTOR, Q.C.:

24 Q. Now, Ms. Predham, you indicated that your  
 25 knowledge level prior to this coming on in

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1 2005 in terms of immunohistochemistry, anyhow,  
 2 would have been fairly low, as was I would  
 3 think a lot of people who ultimately got  
 4 involved. In terms of the laboratory medicine  
 5 program overall, you indicated yesterday that  
 6 at one point you were the quality facilitator  
 7 for the laboratory medicine program. Had you  
 8 spent much time actually in the laboratory,  
 9 either St. Clare's or at the Health Sciences?

10 MS. PREDHAM:

11 A. Over the years I've had the opportunity to be  
 12 in the lab several times, different parts of  
 13 the lab, and, you know, we've had occurrence  
 14 that have happened that have required an  
 15 investigation, that I've talked to various  
 16 technicians and physicians throughout the lab  
 17 over those years.

18 CHAYTOR, Q.C.:

19 Q. Okay, and in -

20 MS. PREDHAM:

21 A. But never immunohistochemistry.

22 CHAYTOR, Q.C.:

23 Q. Never in the IHC portion of the lab?

24 MS. PREDHAM:

25 A. No.

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1 CHAYTOR, Q.C.:

2 Q. So no experience at all with that, okay. If

3 we could have, please, P-0697, and these are

4 minutes of a meeting of the laboratory

5 program, divisional managers meeting, and it's

6 March 4th of 2007, and you'll see that Vern

7 Whelan is present, Lynn Wade, and these are

8 just names that we've heard before, and Mr.

9 Gulliver is absent. Under QI issues on page

10 two of this exhibit, it says, "The Internal

11 Advisory Committee for the laboratory program

12 has been set up and the first meeting held.

13 The membership is as follows", and again we

14 see Mr. Whelan as program director, Dr.

15 Haegert as clinical chief, and then a number

16 of other physicians, and then Lynn Wade,

17 manager of client services, and we see

18 yourself mentioned as QI facilitator, and it

19 says, "Membership will rotate and the terms of

20 reference are being established. Divisional

21 sub-committees will be set up and will report

22 back to the IAC, which will probably meet

23 every second month, and the IHC will report

24 once a year to the Senior Advisory Committee".

25 What do you recall about this, the setting of

Page 110

1 an Internal Advisory Committee for the lab

2 program and what was to be the mandate of that

3 committee?

4 MS. PREDHAM:

5 A. Well, the structure at the time, each program

6 was asked to, and department as well, was

7 asked to set up internal and external advisory

8 committees, and the internal advisory

9 committee would be looking at, you know, the

10 goals, the objectives, indicators, policies

11 within that program and department, and

12 fundamentally would advise the program

13 director and clinical chief on developing

14 their quality report which would go to--it was

15 called Senior Advisory Committee at that time,

16 that was early '97, but became Corporate

17 Quality Initiatives.

18 CHAYTOR, Q.C.:

19 Q. So that's the same as Corporate Quality, okay.

20 MS. PREDHAM:

21 A. I'm pretty sure, yeah.

22 CHAYTOR, Q.C.:

23 Q. And I believe Dr. Haegert had thought that you

24 were instrumental in initiating this internal

25 advisory committee?

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1 MS. PREDHAM:

2 A. Oh, it might have been. That was -

3 CHAYTOR, Q.C.:

4 Q. He wanted to give you credit.

5 MS. PREDHAM:

6 A. Oh, did he? Good. Well, the structure was

7 set up, the quality structure was set up, and

8 all our--especially at that time we were only

9 new to the job and establishing, so I guess

10 instrumental would have been "we have to set

11 up an internal advisory committee and I think

12 it's about time".

13 CHAYTOR, Q.C.:

14 Q. So it may have been your suggestion?

15 MS. PREDHAM:

16 A. Yes, but the structure was this was what all

17 program leadership were asked to do. The

18 External Advisory Committee was more

19 successful in some programs than others. That

20 was--the concept behind the external one was

21 that they would look at stakeholders in the

22 organization or outside the organization who

23 use the service, and that would be who would

24 be on the External Advisory Committee.

25 Certain areas such as mental health had a much

Page 112

1 more successful one because they were--they

2 were--they had a patient/client advisory

3 committee set up at the Waterford that

4 preexisted that. So with the lab, with an

5 external advisory committee, it would be more

6 users of their system was the intent there.

7 CHAYTOR, Q.C.:

8 Q. Okay, and according to these minutes, terms of

9 reference were being established. Did those

10 ever get drafted?

11 MS. PREDHAM:

12 A. I do believe so. I think the lab Internal

13 Advisory Committee did meet for a period of

14 time.

15 CHAYTOR, Q.C.:

16 Q. And that was going to be my next question,

17 whether or not--what happened to this

18 committee, did it get off the ground, how

19 frequently did it meet, and what ultimately

20 happened to it?

21 MS. PREDHAM:

22 A. I do remember the committee meeting. I can

23 remember a couple of meetings distinctly,

24 like, right off the top of my head. I

25 remember talking about, you know, certain

Page 113

1 issues that were--I guess one of the key  
 2 things at this point in time was that they had  
 3 to come up with standardized practice  
 4 throughout the city, throughout the Health  
 5 Care Corporation, and for a service department  
 6 like the lab, that was--that was a key thing  
 7 that they had to do. If you have a certain  
 8 practice in one area, you had to have the same  
 9 practice in all areas now that you're one  
 10 organization, or you have to have reasons why  
 11 you can't have that, and also with the lab, I  
 12 know one of the first things that they were  
 13 doing was they were combining the biochemistry  
 14 labs and the microbiology labs. I'm not sure  
 15 of the timelines on that, but that would have  
 16 been some key activities that they would have  
 17 been involved in, but also practices that they  
 18 had--I can remember this meeting distinctly,  
 19 but I can also remember another meeting that  
 20 was held in which the discussion of panic  
 21 values, you know, what the process is if you  
 22 get a panic value in the lab. The practice  
 23 was slightly different at the different  
 24 hospitals, so they had to come up with a  
 25 standard policy for that. So I can remember

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1 that draft policy coming to this group and  
 2 having that discussion on the process there.  
 3 CHAYTOR, Q.C.:  
 4 Q. And so you were--this was after the Health  
 5 Care Corporation came into existence?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And you were trying to standardize processes  
 10 for the laboratory medicine program?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. At that time. By the time you were no longer  
 15 responsible as QI facilitator for the  
 16 laboratory program, was this committee still  
 17 active?  
 18 MS. PREDHAM:  
 19 A. I can't remember that. I know--if this was--I  
 20 think this was March of '97. So I wouldn't  
 21 have been linked with them after January of  
 22 '98, but I can remember a couple of meetings,  
 23 like I said, but I don't know.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, and if we could have then, please, P-

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1 0056, and this is an administrative policy  
 2 manual and the section is quality and it's  
 3 consumer feedback. If we could--actually, I  
 4 think it's page 12, the one I was more  
 5 interested in bringing your attention to.  
 6 Yes, this is the occurrence reporting one. So  
 7 I assume this is the one we spoke of earlier?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. This particular one is dated October 22nd,  
 12 1997. That's the original date, I understand  
 13 the "O" to mean, and it's from quality  
 14 occurrence reporting, VP Corporate Affairs,  
 15 and do you recognize this signature?  
 16 MS. PREDHAM:  
 17 A. George Tilley.  
 18 CHAYTOR, Q.C.:  
 19 Q. George Tilley, and the policy states, "The  
 20 occurrence reporting process is a component of  
 21 the Health Care Corporation's quality plan in  
 22 ensuring the ongoing monitoring, evaluation,  
 23 and improvement of quality care and service",  
 24 and occurrence is defined as any event,  
 25 accident, error, or circumstance which is not

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1 in keeping with expected process or outcome of  
 2 care or service, and occurrences may result in  
 3 any injury to an individual, damage, or loss  
 4 of equipment or property, and this is the one  
 5 that was in place when you took on risk  
 6 management, I take it, in 1998?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Or the risk manager, I should say, position,  
 11 and then you told us that you had another  
 12 critical incident policy?  
 13 MS. PREDHAM:  
 14 A. Critical occurrence policy.  
 15 CHAYTOR, Q.C.:  
 16 Q. Critical occurrence policy also drafted. On  
 17 page 13 of the document, it refers to clinical  
 18 outcome, "The assessment and treatment the  
 19 patient may need arising from an occurrence",  
 20 and--sorry, over here, if you see outcome, the  
 21 result of a particular event, and then we have  
 22 clinical outcome, the assessment and treatment  
 23 a patient may need arising from an occurrence.  
 24 Then page 14, "Responsibility. Occurrence  
 25 report forms are available through stores at

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1 each site, and any staff members that  
 2 observes/discovers the occurrence, after  
 3 providing immediate attention to the  
 4 situation, shall initiate an occurrence report  
 5 at the time of the occurrence according to the  
 6 guidelines", which include, and then there's a  
 7 list of guidelines, and document facts, a  
 8 patient's condition on health record where  
 9 applicable, do not place occurrence report or  
 10 reference occurrence report on the health  
 11 record. Ms. Predham, what did you understand  
 12 why was that the policy not to put the  
 13 occurrence record or even reference that one  
 14 had been filled out on the health record?  
 15 MS. PREDHAM:  
 16 A. That is as old as when I first came into  
 17 nursing. That was always the thing that you  
 18 do not do that. The primary thing, I guess,  
 19 is to ensure confidentiality of the person  
 20 filling it out, like, you wanted to make sure  
 21 that it's a fairly confidential process if  
 22 you're going to fill one out and put your name  
 23 on it, but also is--you know, later when the  
 24 Evidence Act came in, is to try to ensure that  
 25 it remains protected under the Evidence Act.

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1 It's not part of the health record, it's not  
 2 part of the clinical process, it's a quality  
 3 assurance activity, and I guess it's to  
 4 differentiate between the two of those.  
 5 CHAYTOR, Q.C.:  
 6 Q. So while the person who is filling out the  
 7 occurrence report signs their name, they  
 8 understand that they're doing that  
 9 confidentially and that that will never be  
 10 disclosed?  
 11 MS. PREDHAM:  
 12 A. Right.  
 13 CHAYTOR, Q.C.:  
 14 Q. And were occurrence reports then treated with  
 15 a degree of protection from subsequent  
 16 disclosure?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. And what was the basis for that, what is--is  
 21 it because it was considered to be a quality  
 22 initiative?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. And something then protected under the  
 2 Evidence Act?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And that was always the position taken by  
 7 Health Care Corporation, and you say as long  
 8 as you've been a nurse, so even before that?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And what about the current situation in terms  
 13 of how are occurrence reports treated?  
 14 MS. PREDHAM:  
 15 A. The same--the same way. When we decided to  
 16 put in the electronic version, it would be  
 17 much easier if we could link it somehow with  
 18 some kind of database of patient demographics,  
 19 it would save a lot of time, but we didn't  
 20 want to integrate it any part with the  
 21 clinical record, we wanted it to remain as a  
 22 standalone system.  
 23 CHAYTOR, Q.C.:  
 24 Q. And the program department management section,  
 25 this is now on page 15 of the exhibit, and I

Page 120

1 take it this means the program/department  
 2 management, that would be the program who's  
 3 reporting the incident?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. As well as--or the department at that time.  
 8 That doesn't refer to the--does that refer at  
 9 all to the QI department?  
 10 MS. PREDHAM:  
 11 A. No, no, that's--the Health Care Corporation  
 12 had program management for the clinical  
 13 programs, but all the other, either support  
 14 programs, or clinical support, or support  
 15 programs were referred to as departments. So  
 16 anywhere you see program, it would be  
 17 program/department. You're just referring to  
 18 the different areas in the organization.  
 19 CHAYTOR, Q.C.:  
 20 Q. So review the occurrence, initiate an  
 21 investigation and follow up process, that  
 22 would be the department or program, for  
 23 example, the laboratory medicine program?  
 24 MS. PREDHAM:  
 25 A. Right.

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1 CHAYTOR, Q.C.:

2 Q. But your department would also have a role

3 once you received the occurrence report? You

4 would have a role in actually initiating and

5 following up?

6 MS. PREDHAM:

7 A. Yes, and I think there should be a section

8 there about our department's role.

9 CHAYTOR, Q.C.:

10 Q. "Discuss all occurrences resulting in actual

11 or potential patient injury, or that have

12 implication for significant complaint.

13 Forward completed occurrence form within 48

14 hours to your staff", to staff of Quality

15 Initiatives, "and report significant

16 occurrences immediately to the applicable VP

17 or Vice President on call, and to Risk Manager

18 by next working day". Okay, so they would be

19 expected if it were what seemed to be a

20 significant occurrence to let the VP know and

21 yourself?

22 MS. PREDHAM:

23 A. And that was--when we did the critical

24 occurrence policy, it was always there as part

25 of the policy, but we wanted to strengthen

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1 that and put more substance around it.

2 CHAYTOR, Q.C.:

3 Q. Okay, and then page 16 is the part for the

4 quality initiatives program, and it says, "To

5 monitor trend and provide summary reports on

6 occurrences to the program department

7 leadership on a quarterly basis and upon

8 request". So I guess more frequently if

9 requested. "Retain all original occurrence

10 reports and copies of related follow up

11 forms", and does that still happen, Ms.

12 Predham, or do you keep them for a certain

13 period of time?

14 MS. PREDHAM:

15 A. We keep them two years plus the fiscal, and I

16 think we wrote up--when we decided we were

17 actually running out of room, we wrote up a

18 policy to confidentially destroy them after a

19 certain period of time.

20 CHAYTOR, Q.C.:

21 Q. And will that still be the situation once it's

22 done electronically or will you be able to

23 keep them longer?

24 MS. PREDHAM:

25 A. Well, there won't be any paper copies then.

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1 It'll be all on the database and we'll have

2 them.

3 CHAYTOR, Q.C.:

4 Q. But -

5 MS. PREDHAM:

6 A. We do have a -

7 CHAYTOR, Q.C.:

8 Q. But it still exists, the document--the record

9 would still exist?

10 MS. PREDHAM:

11 A. Right, we do have--whatever goes in the

12 database is still there from '97, so we still

13 have that, but we don't have the paper--pieces

14 of paper.

15 CHAYTOR, Q.C.:

16 Q. Okay. "Assist programs/departments in

17 identifying, controlling or preventing their

18 risk issues". I take it that's the proactive

19 aspect, and the "Risk Manager liaises with the

20 insurer and/or legal counsel as appropriate",

21 and we discussed that. Then if I could have,

22 please, P-0056, page eight, and this is the

23 critical occurrence incident review, the

24 original date being September 30th, 1999, and

25 it's revised June 20th, 2002. So I take it

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1 this is the policy that you were involved in

2 having created?

3 MS. PREDHAM:

4 A. Yes.

5 CHAYTOR, Q.C.:

6 Q. And it pertains to critical occurrences

7 incidents review. It was--and it's signed off

8 here by Pamela Elliott, and it was revised in

9 June of 2002, and do you recall were you

10 involved in that time and what the revisions

11 would have been about?

12 MS. PREDHAM:

13 A. I can't remember what the revisions were

14 about. I remember we revised it and we also

15 did a lot of education around the organization

16 as well with the managers about that, but I

17 can't remember what the revisions would have

18 been.

19 CHAYTOR, Q.C.:

20 Q. Okay, and this is similar to what we discussed

21 we have on page nine of the document, the

22 procedure, and who would play various roles

23 and, for example, you mentioned about meeting

24 to determine who will chair the investigative

25 team and designate who liaises with the

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1 family, and the role of the VP and the  
 2 clinical chief and then quality initiatives  
 3 risk manager notifies insurer, secures and  
 4 reviews chart and related documents and  
 5 equipment. If student is involved, notifies  
 6 appropriate school. So it would be the  
 7 responsibility of the risk manager, and we've  
 8 talked about notifying the insurer, but  
 9 securing and reviewing the chart and related  
 10 documents and equipment, what would that be  
 11 referring to?  
 12 MS. PREDHAM:  
 13 A. Well, that's--you know, you'd have to look at  
 14 the chart, see what the chart says. It's one  
 15 of the processes that you would go through,  
 16 one of the activities that you would go  
 17 through, anyway, and, of course, you mentioned  
 18 in the occurrence report there was loss  
 19 control, so any documents or equipment that  
 20 was involved, you'd have to ensure that that  
 21 was retained and locked up.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay.  
 24 MS. PREDHAM:  
 25 A. Or secured.

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1 CHAYTOR, Q.C.:  
 2 Q. And on page 10, it says here, "Note. If any  
 3 of the leadership team members are involved in  
 4 the critical occurrence, the vice president  
 5 will designate alternates to investigate, and  
 6 I take it the reason there being that you  
 7 wouldn't want to those people to be put in any  
 8 potential perceived or actual conflict of  
 9 interest?  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. And if we could have, please, page 18 of this  
 14 document, and this section is called  
 15 legal/ethics guidelines on disclosure of  
 16 adverse events, and this is dated September  
 17 9th, 2004, and signed. Do you recognize this  
 18 signature?  
 19 MS. PREDHAM:  
 20 A. I assume it's George Tilley, but that looks  
 21 like a "J" at the beginning.  
 22 CHAYTOR, Q.C.:  
 23 Q. And August 1st, 2005, and I think we may have  
 24 heard that it was Dr. Williams, but I'm not  
 25 sure now, it's been a while.

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1 THE COMMISSIONER:  
 2 Q. VP of Medical Services.  
 3 CHAYTOR, Q.C.:  
 4 Q. VP Medical.  
 5 MS. PREDHAM:  
 6 A. Yeah, but it looks like a "J" at the  
 7 beginning.  
 8 CHAYTOR, Q.C.:  
 9 Q. And then this indicates the definition of an  
 10 adverse event and how it's defined, and this  
 11 is originating on September 9th, 2004. Do you  
 12 know, Ms. Predham, was there a similar  
 13 disclosure policy prior to this?  
 14 MS. PREDHAM:  
 15 A. No.  
 16 CHAYTOR, Q.C.:  
 17 Q. There was nothing in place before?  
 18 MS. PREDHAM:  
 19 A. No.  
 20 CHAYTOR, Q.C.:  
 21 Q. And you were involved in drafting this?  
 22 MS. PREDHAM:  
 23 A. There was a draft done, I believe through  
 24 Ethics had done an original draft. It was  
 25 much longer than this is my memory of it, but

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1 I was involved in finalizing this draft and a  
 2 lot of the communication with the clinical  
 3 chiefs before it was finally approved.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and an adverse event is defined "as an  
 6 unexpected and undesired incident directly  
 7 associated with the care or services provided  
 8 to the patient and/or an incident that occurs  
 9 during the process of providing health care  
 10 and results in patient injury or death and/or  
 11 an adverse outcome for a patient, including an  
 12 injury or a complication", and I'm just  
 13 wondering in terms of by this point in time,  
 14 the difference between an adverse event and a  
 15 critical occurrence event?  
 16 MS. PREDHAM:  
 17 A. Well, see at this time patient safety  
 18 literature was growing and there was some  
 19 disagreement on what you would call, you know,  
 20 an occurrence, and adverse event was more in  
 21 the literature. As well, just before this,  
 22 there was a provincial patient safety  
 23 committee established that was coordinated  
 24 through the Department of Health, and they had  
 25 surveyed all the boards and asked if we could



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1 agree to use the definitions that were used by  
 2 the patient safety dictionary provincially for  
 3 consistency purposes, which we all agreed to,  
 4 and then this was the first one where we used  
 5 one, so we had agreed to do that and we  
 6 weren't really happy with the definition, but-  
 7 -you know, because it's kind of cumbersome,  
 8 but that's the terminology that we went  
 9 forward with.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay, so if something were, though--I take it  
 12 the other policy I had just directed you to  
 13 which came out of--it was a quality policy on  
 14 the critical occurrence/incident review, that  
 15 remained in effect?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. Because that was more geared towards how -  
 20 MS. PREDHAM:  
 21 A. To investigate it.  
 22 CHAYTOR, Q.C.:  
 23 Q. - you were going to go about investigating the  
 24 issue, and then this is dealing with how it's  
 25 actually going to be disclosed?

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay. So both of those policies continue to  
 5 exist side by side?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay.  
 10 THE COMMISSIONER:  
 11 Q. Ms. Chaytor, wherever you can find a  
 12 convenient spot, we'll take the morning break.  
 13 CHAYTOR, Q.C.:  
 14 Q. And in terms of the procedure, "provide prompt  
 15 attention to the situation or eliminate or  
 16 reduce immediate and potential risk, and  
 17 initiate an occurrence report" and then it  
 18 actually refers back to your policy on  
 19 occurrence reporting, and it's the same number  
 20 as what I'd shown you on page 12. So that  
 21 policy too, I take it, was still in existence?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. Yes, okay. This would be a convenient time,

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1 thank you.  
 2 THE COMMISSIONER:  
 3 Q. All right then, we'll take 15 minutes.  
 4 (BREAK)  
 5 THE COMMISSIONER:  
 6 Q. Please be seated. Ms. Chaytor.  
 7 CHAYTOR, Q.C.:  
 8 Q. Thank you, Commissioner. Registrar, if we  
 9 could have, please, P-0057? And those, we  
 10 understand, are some current policies that are  
 11 in place.  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And you'll see the first one here on page one  
 16 is Disclosure of Adverse Events, and original  
 17 approval date is August 28th, 2007, and to be  
 18 reviewed then December 2007, and do you know  
 19 whether or not the review of this policy took  
 20 place?  
 21 MS. PREDHAM:  
 22 A. It's currently under review now. We were  
 23 waiting--we put this in as an interim policy  
 24 with Eastern Health waiting the disclosure  
 25 guidelines that CPSI were releasing. So in

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1 anticipation of that, we figured that it would  
 2 be around that time, but I think it was more  
 3 in the spring that they got released.  
 4 CHAYTOR, Q.C.:  
 5 Q. So it's still currently under review?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And so this document is still the document  
 10 that's in effect?  
 11 MS. PREDHAM:  
 12 A. Yes, because the other one is being developed  
 13 right now.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and this, of course, discusses, as the  
 16 name suggests, "disclosure of adverse and  
 17 sentinel events to patients, clients,  
 18 residents, and substitute decision makers must  
 19 occur in a candid and timely fashion and  
 20 follow specific standardized protocol" and  
 21 then under the disclosure itself, it speaks of  
 22 "the person making the disclosure must:  
 23 concentrate on what happened and the possible  
 24 consequences, remain factual, refrain from  
 25 opinions on care and/or service of others,

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1 take the lead in disclosure, outline a plan of  
 2 care to rectify the harm and prevent  
 3 recurrence for this person and others," and  
 4 what would you expect that to include?  
 5 MS. PREDHAM:  
 6 A. Just before I answer that question, this  
 7 policy and the preceding one was always--was  
 8 written in a single patient kind of mind set  
 9 when we wrote that. So you had a single  
 10 patient that something happened to and you  
 11 were telling them about that. So that's where  
 12 that came from. So here, the clinician or the  
 13 person who is speaking to the patient or the  
 14 family would be saying this is what we've done  
 15 since then and this is how we're going to  
 16 prevent that from happening again.  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes, and of course, there were such meetings  
 19 with respect to the ER/PR issue where there  
 20 were individual meetings with patients.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. So this would be--D would be talking about  
 25 well, here's how we're going to -

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1 MS. PREDHAM:  
 2 A. It could be handling your individual care  
 3 right now, so you know, you are going--this is  
 4 what we're going to have to do now. You're  
 5 going to have to have this other test done.  
 6 You're going to have to have surgery,  
 7 whatever. And this is what we've put in place  
 8 to prevent this from happening again.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay. So it would have to involve some  
 11 discussion with the patient or the person  
 12 affected as to what had happened and what was  
 13 being done to rectify the issues that had been  
 14 identified?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And it says "document the discussion in the  
 23 health record," and then the linkages for this  
 24 particular policy refer to the occurrence  
 25 reporting policy, sentinel event policy and

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1 the consent policy, and the next page has the  
 2 definition of adverse event again. And then  
 3 on page five, we have the--and again, this is  
 4 quality and risk management's occurrence  
 5 reporting, and this one was approved as well  
 6 August 28th, 2007, December 2007, and has this  
 7 one been reviewed?  
 8 MS. PREDHAM:  
 9 A. No, because the new policy will come in place  
 10 when we're establishing the electronic  
 11 occurrence reporting system, so you know.  
 12 CHAYTOR, Q.C.:  
 13 Q. So you'll update it then?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, all at the same time. So currently,  
 18 this is the existing policy, without any  
 19 revisions?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And under overview, "the occurrence reporting  
 24 process is a key component of Eastern Health's  
 25 quality and risk management framework in

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1 pursuit of improved patient, client, resident  
 2 safety" and "the system facilitates the  
 3 identification, monitoring and analysis of  
 4 adverse events, sentinel events, hazards,  
 5 incidents and near misses" and we've discussed  
 6 some of that this morning. "Occurrence  
 7 reporting is not designed to place blame on  
 8 individuals. Eastern Health is committed to  
 9 upholding the following characteristics of a  
 10 culture of safety. Individuals are encouraged  
 11 to raise concerns about actual and potential  
 12 hazards and risks and safety issues.  
 13 Individual and organization accountability are  
 14 promoted."  
 15 And I'm wondering, Ms. Predham, what this  
 16 means "individual and organization  
 17 accountability are promoted" and how it's  
 18 promoted through this?  
 19 MS. PREDHAM:  
 20 A. Well, I guess, as I mentioned, you know, the  
 21 85/15 rule, 80/20 rule, it's a system error  
 22 and that you have that understanding that the  
 23 majority of things that go wrong in an  
 24 organization is because of the way that we do  
 25 things. However, you do have a small part of

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1 that in which the individual is accountable  
 2 for their actions and I guess, it's just  
 3 recognizing that.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, so while somebody can be accountable or  
 6 held accountable for their actions, the  
 7 occurrence reporting in and of itself is not  
 8 designed to place any blame on any particular  
 9 individual?  
 10 MS. PREDHAM:  
 11 A. No.  
 12 CHAYTOR, Q.C.:  
 13 Q. So it's a differentiation between someone  
 14 being blamed, as opposed to someone being held  
 15 accountable, should it be deemed appropriate  
 16 for that to happen?  
 17 MS. PREDHAM:  
 18 A. Exactly.  
 19 CHAYTOR, Q.C.:  
 20 Q. And "investigating errors requires evaluating  
 21 of all systemic factors that may have  
 22 contributed to errors, instead of focusing on  
 23 individuals to blame. Investigation of  
 24 occurrences provides opportunities to improve  
 25 the safety of services delivered. Feedback on

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1 occurrences is important to learning. Under  
 2 the Evidence Act, occurrence reports are  
 3 protected from legal proceedings." And I'm  
 4 just wondering with respect to that, and if we  
 5 look back to page two, the disclosure policy,  
 6 and documenting the discussion in the health  
 7 record, including the discussion of how to  
 8 rectify the harm and prevent recurrence, how  
 9 do you go about doing that while at the same  
 10 time the occurrence report being afforded any  
 11 protection?  
 12 MS. PREDHAM:  
 13 A. Well, I guess, if you're--you know, you're  
 14 sitting down and disclosing to a patient and  
 15 part of it is that you're going to outline a  
 16 plan of care. I don't know, looking at that  
 17 now, how much detail would be in a health  
 18 record from, you know, clinicians disclosing  
 19 an adverse event, how much would be in there  
 20 about what steps we're doing to prevent this  
 21 from happening again actually, now that I read  
 22 this in this venue. But you know, it would be  
 23 very appropriate to put in there that, you  
 24 know, discuss the implications and the impact  
 25 on this patient and what we're planning on

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1 doing to rectify, you know, whether the care  
 2 or treatment or whatever. There may be some  
 3 reference to discuss current procedures or  
 4 changes that have been made, but I don't think  
 5 that there would be a lot of detail put into  
 6 the health record about what as going forward.  
 7 CHAYTOR, Q.C.:  
 8 Q. And whether it's in the health record or not,  
 9 in terms of disclosing it to the patient in  
 10 the meeting with the patient, would there be  
 11 any difficulty in doing that?  
 12 MS. PREDHAM:  
 13 A. No, because you're disclosing facts and facts  
 14 are never held back. They're not--you know,  
 15 they're not privileged or anything like that,  
 16 the facts of it all. The reason that you  
 17 encourage the occurrence reporting is to be  
 18 kept confidential is that the--even though you  
 19 want them to report the facts only, there  
 20 tends to be a lot of opinion in occurrence  
 21 reporting.  
 22 CHAYTOR, Q.C.:  
 23 Q. So for example, your understanding is under  
 24 the Evidence Act, while the occurrence report,  
 25 you could claim that the occurrence report is

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1 privileged, any facts that are contained in  
 2 the occurrence report would not be afforded  
 3 protection?  
 4 MS. PREDHAM:  
 5 A. Exactly.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, and that would be true also of any  
 8 external review reports or any reports that  
 9 are claimed to be peer review reports?  
 10 MS. PREDHAM:  
 11 A. Exactly.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay. So for example, any finding by Dr.  
 14 Banerjee that pathologists were not--that he'd  
 15 saw instances, looking at slides, where  
 16 pathologists were not looking for internal  
 17 controls, that would be a fact?  
 18 MS. PREDHAM:  
 19 A. That's a fact.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay, and there wouldn't be any particular  
 22 protection of that information? That's your  
 23 understanding?  
 24 MS. PREDHAM:  
 25 A. That's my understanding.

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1 CHAYTOR, Q.C.:

2 Q. So in terms of what then--what would be held

3 back from being told to the patient or

4 otherwise disclosed?

5 MS. PREDHAM:

6 A. From a peer review, quality review, that type

7 of -

8 CHAYTOR, Q.C.:

9 Q. Yes, from either what shows up in your

10 occurrence report, because I would think an

11 occurrence report, this is your employee

12 writing down, here's what happened. What

13 would be held back from an occurrence report

14 that wouldn't be able to be disclosed?

15 THE COMMISSIONER:

16 Q. It seems to me that there's two different

17 questions here. One thing is what's being

18 told to the patients.

19 CHAYTOR, Q.C.:

20 Q. Yes.

21 THE COMMISSIONER:

22 Q. What's being put on the chart, and the other

23 is what goes in the occurrence report.

24 CHAYTOR, Q.C.:

25 Q. Yes.

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1 THE COMMISSIONER:

2 Q. Do you make any distinction between what's

3 being told to the patient and what goes on the

4 chart?

5 MS. PREDHAM:

6 A. No. I mean, if the--the way the disclosure

7 typically happens, and that's covered off with

8 a disclosure policy, is that the physician

9 who's involved in the situation or it could be

10 the clinical chief in that area, depending on

11 the circumstances, would sit and talk to the

12 family and say "this happened to you. We have

13 to tell you, you know, you've received the

14 wrong treatment" or the wrong surgery or

15 whatever, and disclose that information to

16 them, and then that discussion there would be

17 reflected in the patient's record. So you

18 have a record in their health record that they

19 have been disclosed this information.

20 THE COMMISSIONER:

21 Q. But if you have a discussion with a patient's

22 family or a patient having disclosed an error,

23 it's one thing to walk in and say, you know,

24 "I took off the wrong leg" and that's all

25 pretty factual and pretty evident, in terms of

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1 your being able to say well, that's just

2 factual. But it seems to me that the

3 conversation which follows is going to involve

4 the expression of an opinion in the normal

5 course. If you have received the wrong

6 medication, if you have been misdiagnosed, if

7 you have had an incident in the OR during the

8 course of removal of one organ and the other

9 one gets damaged, it seems to me that unless

10 you're going to tell the patient the mere fact

11 that it occurred, the following dialogue has

12 to involve the opinion of the person telling

13 them about the impact, how it occurred, the

14 impact on the family, or otherwise it's going

15 to be a strange conversation, and it's going

16 to sound to the patient like you're trying to

17 keep information from them rather than

18 disclose.

19 MS. PREDHAM:

20 A. And I guess, just taking it back a little bit.

21 If we had--if we got a call tomorrow that, you

22 know, someone had the wrong organ removed in

23 the OR, you'd have to--you know, you have to

24 disclose them and tell them that an

25 investigation is underway to determine how

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1 exactly that happened, because of course, they

2 had to be told immediately. During that

3 investigation, you may go through a quality

4 review process where you get other people

5 involved and you want them to have the ability

6 to tell you exactly what they think, like it

7 could have been this person's fault or that

8 person, you know, whatever, that type of

9 discussion. But the facts of what you piece

10 together at the end of the day has to be told

11 to the patient because that's--this is what we

12 think happened. This is what we think the

13 facts are, or this is what we know the facts

14 are.

15 So I guess, unless I gave you an actual

16 concrete example, it's hard to explain, but

17 it's--quality review, peer review is a

18 critical tool that we have to keep the concept

19 of it protected because we have to make sure

20 that people are willing to talk to us and tell

21 us exactly what they think and be fully open

22 with us. So if we don't keep that protected,

23 then we won't have--they won't come forward

24 and tell us what they think happened, because

25 that's the only way that we're going to know.

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1 In a circumstance like that, the best  
 2 that you could probably do is that we think  
 3 this is what happened, or we think that these  
 4 are the contributing factors, and then that's  
 5 what you go forward and tell the family,  
 6 because that's what you believe really  
 7 happened. But it wouldn't be, you know,  
 8 Doctor so and so really thinks it's this and  
 9 Doctor so and so thinks it's that. It would  
 10 be this is our understanding of what could  
 11 have happened here, and this is what we tell  
 12 them. You have to be completely honest with  
 13 the family, but you also have to protect that  
 14 ability for people to tell you what they  
 15 really think happened.

16 THE COMMISSIONER:  
 17 Q. When you bring it down to the kinds of  
 18 information that I've been getting here, it  
 19 seems to me that there is a--I will say  
 20 possibility, but perhaps a probability that in  
 21 that process of protecting the information  
 22 which you hold so dear, you could mislead.

23 MS. PREDHAM:  
 24 A. I would say that there could be a possibility,  
 25 but I don't think that there would be. I know

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1 that sounds a bit odd, but I've been involved  
 2 in a lot of circumstances where I had to tell  
 3 family members bad news, and--I'm sorry. But,  
 4 in those circumstances--can we just -

5 CHAYTOR, Q.C.:  
 6 Q. Take your time.

7 MR. SIMMONS:  
 8 Q. Would you like to take a break?

9 THE COMMISSIONER:  
 10 Q. Do you want to take a break? Take a couple of  
 11 moments.

12 MS. PREDHAM:  
 13 A. A couple of minutes.

14 THE COMMISSIONER:  
 15 Q. Sure.  
 16 (BREAK)

17 THE COMMISSIONER:  
 18 Q. Please be seated. Ms. Chaytor.

19 CHAYTOR, Q.C.:  
 20 Q. Thank you, Commissioner. You okay now?

21 MS. PREDHAM:  
 22 A. Yes, sorry about that.

23 CHAYTOR, Q.C.:  
 24 Q. No troubles. Ms. Predham, I just want to  
 25 explore this a bit further, in terms of how

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1 you balance then what you understand can be  
 2 protected as opposed to what gets told to the  
 3 patient and just explore that a little bit  
 4 more with you, and in the example that you  
 5 were given, in terms of if you had Dr. A say  
 6 one thing and Dr. B say something else, in  
 7 that situation, what do you tell the patient?

8 MS. PREDHAM:  
 9 A. You'd have to--you know, you'd have to work  
 10 through and you'd have to feel very  
 11 comfortable that you've got the story of what  
 12 happened here. If people had different  
 13 opinions, then that would lead you to further  
 14 investigation. So if somebody had "I think  
 15 this is a contributing factor, I think," well  
 16 then, you'd have to go and investigate that.  
 17 You'd have to look at--if somebody is saying  
 18 that's not the proper practice or this is what  
 19 we need to do here or we didn't do this and  
 20 this is what should be done, well then, you  
 21 have to investigate that to see what you can  
 22 determine, and at the end of the day, you  
 23 should be able to piece the story together  
 24 exactly what happened, and you know,  
 25 sometimes--each one is different, but you try

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1 to actually get to what happened, and with a  
 2 family member, we, more than one time, have  
 3 gone through a step-by-step process of what  
 4 led to the circumstances which have affected  
 5 either them or their family member, and given  
 6 that to them in writing that at such and such  
 7 a time this has happened, just a concrete type  
 8 steps and then use that to say this is a  
 9 contributing factor.

10 There have been times when we have given  
 11 a summary of opinion and, you know, not said  
 12 to this is so and so's opinion or Dr. so and  
 13 so's opinion, that this is what happened, this  
 14 is the best guess that we can have that  
 15 happened here, you know, and basically, that's  
 16 what it is. We can't narrow it down any  
 17 further, but this is what we think has  
 18 happened.

19 CHAYTOR, Q.C.:  
 20 Q. And so, and again, your understanding is that  
 21 anything that's facts, any facts that you've  
 22 determined or any expert retained on your  
 23 behalf have determined, any factual--anything  
 24 that's factual would be told to the patient  
 25 and your understanding is that that's

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1 permitted, in terms of any protection claimed  
 2 under the Evidence Act?  
 3 MS. PREDHAM:  
 4 A. Oh yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And that's been the position of Eastern Health  
 7 for some time?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. And I take it that's been--there's been legal  
 12 advice sought on that and that's the opinion?  
 13 MS. PREDHAM:  
 14 A. Oh yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and so for example then, in the ER/PR  
 17 issue and anything that may have contributed  
 18 or caused what ultimately happened in  
 19 resulting in changed results over a period of  
 20 time, issues such as fixation issues, lack of  
 21 standard operating procedures, lack of  
 22 documentation in general, issues of  
 23 pathologists not checking the internal  
 24 controls and whether or not that may have been  
 25 able to determine anything, but not having

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1 done that, those types of things, those would  
 2 be facts?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay. So all of that information could have  
 7 been disclosed?  
 8 MS. PREDHAM:  
 9 A. Yes. Now they're facts as such as those were  
 10 things that were found that could be a  
 11 contributing factor, but how big a role that  
 12 they played, that would take the analysis of  
 13 the, you know, fundamental data, I guess, from  
 14 the NLCHI database to go through and say okay,  
 15 for fixation, for example, we had these many  
 16 conversions that went from zero to whatever.  
 17 How many of these had poor fixation? For the  
 18 ones that went from a low expressor to a high  
 19 expressor, how many of these had low fixation?  
 20 So we'd have to--and then how many that stayed  
 21 the same, how many had low fixation? So that  
 22 part, as far as I'm aware, unless that's being  
 23 done right now, up to a little while ago, that  
 24 hadn't been done and that's a critical part  
 25 that has to be looked at.

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1 CHAYTOR, Q.C.:  
 2 Q. But in terms of overall, in terms of--and as  
 3 you say, this is a different situation. You  
 4 weren't dealing with an individual case. So  
 5 overall, looking at the massive retesting and  
 6 how these may have been contributing factors,  
 7 there'd be no--there would have been no  
 8 difficulty in coming out and stating these are  
 9 issues that have been identified? These are  
 10 the facts that we've been able to under cover  
 11 or others, on our behalf, have been able to  
 12 ascertain?  
 13 MS. PREDHAM:  
 14 A. Yes, yes and no. I guess we didn't validate--  
 15 whenever you have a person who comes in to do  
 16 an external review, they're giving their  
 17 opinion on what they see and what process they  
 18 see, and I think before we went out and said  
 19 that these are contributing factors, although  
 20 we're--yes, okay, fixation, it's very clear  
 21 that that seems to be that. I think we'd need  
 22 to have the data just to validate that as  
 23 there, just for our comfort level, to say that  
 24 that is that contributing factor, and I think  
 25 that may have been a bit hesitant in doing

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1 that until we had that information.  
 2 CHAYTOR, Q.C.:  
 3 Q. I'm sorry, what data is it that -  
 4 MS. PREDHAM:  
 5 A. You know, the overall, the retest results. So  
 6 the overall retest results and how many times  
 7 did fixation, that poor fixation was evident  
 8 on the ones that converted.  
 9 CHAYTOR, Q.C.:  
 10 Q. And what was Eastern Health doing to try and  
 11 ascertain that?  
 12 MS. PREDHAM:  
 13 A. Well, that was part of the analysis that we  
 14 were going to be doing once all the results  
 15 were back and the patients were notified and  
 16 all that. That was a critical part in that  
 17 analysis that had to be done.  
 18 CHAYTOR, Q.C.:  
 19 Q. And by the time this Inquiry is called in May  
 20 of 2007, had Eastern Health undertaken that?  
 21 MS. PREDHAM:  
 22 A. No.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay. Ms. Predham, and the issue, I guess, of  
 25 any quality assurance measures or lack of

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1 quality control measures that may have been an  
 2 issue or come into play, and those would have  
 3 been some things that, I take it, in your own  
 4 investigation, you would have determined?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. You would have seen yourself, and some of the  
 9 issues that already spoke of, certainly would  
 10 have been identified by Dr. Carter?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. Apart from the external reviewers, Dr. Carter.  
 15 So in terms of being able to mention those,  
 16 those would be considered facts?  
 17 MS. PREDHAM:  
 18 A. The fact that there was no documentation and -  
 19 CHAYTOR, Q.C.:  
 20 Q. Yes.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And that there was no overall quality  
 25 assurance program, that there was no external

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1 proficiency testing taking place for the IHC  
 2 laboratory.  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. All of those are facts?  
 7 MS. PREDHAM:  
 8 A. All those are facts.  
 9 THE COMMISSIONER:  
 10 Q. You said a little earlier that there might be,  
 11 at the end of the day, a kind of summary of  
 12 opinion. Did I get that right, when you're  
 13 communicating to somebody?  
 14 MS. PREDHAM:  
 15 A. There might have been--I guess what I was  
 16 trying to say that if you were investigating  
 17 something, you may not ever know exactly what  
 18 went wrong in a certain circumstance. So then  
 19 you'd have to say, you know, I guess, this is  
 20 our best guess. This is, of talking to  
 21 everybody, doing an external review, this is  
 22 the opinion that we've come--that we, of what  
 23 has happened in your circumstance. So really,  
 24 you are still only giving an opinion, but you  
 25 have to give a reason of what happened.

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1 THE COMMISSIONER:  
 2 Q. So are you--well, if you have a situation  
 3 where the only opinions you have are those  
 4 from sources that might be protected, are you  
 5 saying that you could do a summary of that  
 6 opinion for the purpose of the discussion with  
 7 the patient, but you couldn't actually let  
 8 them see what the opinion was?  
 9 MS. PREDHAM:  
 10 A. Well, yes, I guess in a way you can, because  
 11 you wouldn't want to say that Dr. X thinks  
 12 this happens, you know, think that this  
 13 happened or this is a contributing factor.  
 14 You could say "we, investigating this, taking  
 15 all the information that we have, think that  
 16 this is what happened." There's been very few  
 17 times that we actually haven't been able to  
 18 elicit exactly what happened. I can't think  
 19 of anything where I haven't been able to  
 20 explain to people that this is what happened,  
 21 these are the series of facts or these are  
 22 the--you know, this is what happened.  
 23 CHAYTOR, Q.C.:  
 24 Q. And Ms. Predham, in this situation, ER/PR  
 25 testing resumed at Eastern Health in February

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1 2007. So I take it, by that point in time,  
 2 Eastern Health had assured itself that it had  
 3 identified the key factors or the contributing  
 4 factors and causes of the issue and had  
 5 addressed them prior to putting the testing  
 6 back in place?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Ms. Predham, you attended some meetings with  
 11 patients regarding the ER/PR issue?  
 12 MS. PREDHAM:  
 13 A. Yes, not very many, but yes, I did.  
 14 CHAYTOR, Q.C.:  
 15 Q. And did you attend any--was it just DCIS  
 16 patient meetings or were there others as well?  
 17 MS. PREDHAM:  
 18 A. I didn't attend those. Actually, I think I  
 19 only attended one early on with Dr. McCarthy.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay, and was it a patient who had changed  
 22 results?  
 23 MS. PREDHAM:  
 24 A. It was the sister of a patient who had changed  
 25 results.

1 CHAYTOR, Q.C.:

2 Q. And was that relative told any of the facts

3 that I just listed?

4 MS. PREDHAM:

5 A. Well, that was early on, so we didn't know any

6 of that. That was, I think the beginning of

7 September 2005.

8 CHAYTOR, Q.C.:

9 Q. Okay. So anything that Dr. Carter had done,

10 in terms of her review, would you have known

11 that at that point in time?

12 MS. PREDHAM:

13 A. I don't think I knew a lot of details of what

14 Dr. Carter had found at that time.

15 CHAYTOR, Q.C.:

16 Q. To your knowledge, during the meetings with

17 the patients, do you know what was told to

18 patients, in terms of disclosing the causes or

19 potential causes of the problem?

20 MS. PREDHAM:

21 A. No, I don't know actually. I don't know how

22 they came up. I know I've spoken to lots of

23 patients on the phone, the confirmed

24 negatives, and some people wanted to know what

25 happened and some people didn't want to know

1 had been identified, did you ever tell them

2 any of those things, such as fixation, such as

3 the lack of quality assurance and quality

4 control measures, the lack of any issues that

5 may have come up in the lab, in terms of

6 standard operating procedures? Were they ever

7 told -

8 MS. PREDHAM:

9 A. I didn't get into detail, other than there

10 was--they wanted to know if it was a person or

11 if it was one, like one thing, like what was

12 the cause, and I said that we had found that

13 there was a contribution of many things that

14 could have caused this but that there was no

15 one individual or a thing that could have

16 caused this.

17 CHAYTOR, Q.C.:

18 Q. And so in asking what is the cause, you

19 understood them to be looking for just one

20 thing?

21 MS. PREDHAM:

22 A. The people I was talking to was looking for

23 that.

24 CHAYTOR, Q.C.:

25 Q. And in your experience in investigating

1 much of anything, and you know, I guess the

2 message that I gave to them was that we were

3 investigating it at that time, up to February

4 of 2006, but also that, you know, we couldn't

5 confirm that we were doing the test as best

6 that we could at the time. So we had to stop

7 doing it right now and then we had to retest.

8 CHAYTOR, Q.C.:

9 Q. And in speaking to the patients who wanted to

10 know, did you tell them any of the potential

11 causes that had been identified up to that

12 point in time?

13 MS. PREDHAM:

14 A. I didn't get into detail of saying that there

15 was fixation. We knew that there was--I guess

16 the biggest message I was trying to tell them

17 was that there wasn't anything obviously the

18 cause, there wasn't one thing that there was a

19 cause, that we had identified several issues

20 that had to be addressed and you know, and we

21 were looking further into it at that level.

22 CHAYTOR, Q.C.:

23 Q. And in terms of telling them what some of

24 those, whether it's one thing or many things,

25 in terms of telling them the many things that

1 incidents and occurrences, is there usually

2 one cause?

3 MS. PREDHAM:

4 A. Sometimes there has been one cause. Sometimes

5 there is, you know, one contributing factor

6 that you can fix and take care of, but most of

7 the times it is a series of events.

8 CHAYTOR, Q.C.:

9 Q. Thinking of the swiss cheese.

10 MS. PREDHAM:

11 A. Yes. But even in the swiss cheese event,

12 usually it's just a gap in a process that is

13 not a cause as such. It's just a -

14 CHAYTOR, Q.C.:

15 Q. It's a contributing factor.

16 MS. PREDHAM:

17 A. If that had been in place, this wouldn't have

18 happened.

19 CHAYTOR, Q.C.:

20 Q. Yes, it's a contributing factor.

21 MS. PREDHAM:

22 A. It's like a stop gap or a double check. But

23 this one here, there was a lot of things that

24 could have contributed to it that we had no

25 way to confirm whether or not it did or not.



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1 You know, like during the process, because the  
 2 process wasn't there any more, because there  
 3 was no documentation, we couldn't go through  
 4 and look and say, okay, there's a period of  
 5 time that there was a lot of conversions or  
 6 something and this lot number of a dilutant  
 7 was used, or you know, there was--so there was  
 8 no way, and we'll never know if there was any  
 9 kind of process thing or documentation or that  
 10 the wrong dilution was used or any of those  
 11 times were wrong or humidity was wrong because  
 12 there's no documentation to verify it.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and why isn't there any documentation to  
 15 verify that?  
 16 MS. PREDHAM:  
 17 A. Those processes weren't set up to document all  
 18 that.  
 19 CHAYTOR, Q.C.:  
 20 Q. And do you know what--where that  
 21 documentation, in terms of your dilutions over  
 22 a period of time, where that information may  
 23 have been kept?  
 24 MS. PREDHAM:  
 25 A. As far as I could ascertain, it wasn't kept.

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1 Now I know there was some information that  
 2 would be computerized, but I've only found  
 3 that out recently, like within the past six  
 4 months, I suppose, but at the time when I was  
 5 over investigating that, there was no records  
 6 at that time. What I was looking for wasn't  
 7 in existence.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and so that came to your attention about  
 10 six months ago, you say, in terms of  
 11 computerized records that may have been  
 12 available?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and how did it come to your attention  
 17 six months ago?  
 18 MS. PREDHAM:  
 19 A. I can't really remember now the circumstances,  
 20 but I know it was--I found out that there was  
 21 other documentation that was in the computer  
 22 and that IT had to be involved in getting that  
 23 out. I think I got notified by IT, whether or  
 24 not I was aware of any records or if I could  
 25 point them in a direction of exactly what they

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1 were looking for, and at that time, I found  
 2 out that there were some records.  
 3 CHAYTOR, Q.C.:  
 4 Q. And so in your investigation of this, that was  
 5 never brought to your attention?  
 6 MS. PREDHAM:  
 7 A. No.  
 8 CHAYTOR, Q.C.:  
 9 Q. And I take it six months ago it would be the  
 10 Ventana records that you were looking at?  
 11 MS. PREDHAM:  
 12 A. Yes, it must have been. Yes, that it would  
 13 have been in the computerized system in that,  
 14 I guess.  
 15 CHAYTOR, Q.C.:  
 16 Q. Well -  
 17 MS. PREDHAM:  
 18 A. I can't -  
 19 CHAYTOR, Q.C.:  
 20 Q. - Eastern Health didn't have -  
 21 MS. PREDHAM:  
 22 A. - I really can't think of it right now.  
 23 CHAYTOR, Q.C.:  
 24 Q. - Eastern Health didn't have the DAKO machine  
 25 -

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1 MS. PREDHAM:  
 2 A. Didn't have the computer, no.  
 3 CHAYTOR, Q.C.:  
 4 Q. - in its possession any more.  
 5 MS. PREDHAM:  
 6 A. So it must have been the Ventana.  
 7 CHAYTOR, Q.C.:  
 8 Q. Yes.  
 9 THE COMMISSIONER:  
 10 Q. I'm sorry, I'm not understanding that. Did I  
 11 take it that IT consulted you because they'd  
 12 been asked to do something and they weren't  
 13 quite sure what they needed to do?  
 14 MS. PREDHAM:  
 15 A. Well, they called about--I hadn't really  
 16 thought about this lately, exactly what it  
 17 was. It was a bit vague and it was something  
 18 to do with some records that were sent over  
 19 and they couldn't locate them, and it was for  
 20 the Commission, I do believe, but they called  
 21 over just in case I knew what--any further  
 22 description because I think, you know,  
 23 somebody who had taken it may have been on  
 24 holidays, so you had somebody who was trying  
 25 to look for something, could I describe this

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1 in any detail, and I didn't know what they  
 2 were talking about.  
 3 THE COMMISSIONER:  
 4 Q. So you, from that conversation, believed that  
 5 there might be records, computerized records  
 6 which had to do with?  
 7 MS. PREDHAM:  
 8 A. Something internal of the processing that they  
 9 went through, some processing part.  
 10 THE COMMISSIONER:  
 11 Q. So some part of the process involved in ER/PR?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 THE COMMISSIONER:  
 15 Q. Might have been computerized--might have  
 16 involved a computer and there might be  
 17 records?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 THE COMMISSIONER:  
 21 Q. Which this particular person was trying to  
 22 retrieve?  
 23 MS. PREDHAM:  
 24 A. Right.  
 25 THE COMMISSIONER:

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1 Q. But they didn't quite know what it was they  
 2 had to retrieve because they were calling you?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 MR. SIMMONS:  
 6 Q. Commissioner, if I might help?  
 7 THE COMMISSIONER:  
 8 Q. If you can.  
 9 MR. SIMMONS:  
 10 Q. Those are the records from the Ventana machine  
 11 that have been produced, and I think there was  
 12 just IM & T were trying to locate the backup  
 13 disc on which the information had been stored.  
 14 It was located after and those have been  
 15 produced.  
 16 THE COMMISSIONER:  
 17 Q. All right. So we're talking here about the  
 18 Ventana records?  
 19 MR. SIMMONS:  
 20 Q. Right, the ones from when the Ventana machine  
 21 was first put into use in January of, going to  
 22 say -  
 23 MS. PREDHAM:  
 24 A. '04.  
 25 MR. SIMMONS:

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1 Q. - '04.  
 2 CHAYTOR, Q.C.:  
 3 Q. The ones that were produced during Barry  
 4 Dyer's evidence?  
 5 MR. SIMMONS:  
 6 Q. Yes, exactly.  
 7 THE COMMISSIONER:  
 8 Q. Thank you, Mr. Simmons.  
 9 CHAYTOR, Q.C.:  
 10 Q. Ms. Predham, so did--in saying that then, did  
 11 it--are you saying that while then it occurred  
 12 to you when this request came to you,  
 13 approximately six months ago, well that it  
 14 occurred to you if this exists on the Ventana  
 15 machine, is there similar documentation we  
 16 could have had from the DAKO computer over the  
 17 relevant time period?  
 18 MS. PREDHAM:  
 19 A. Well, I mean, yes, it occurred to me, but the  
 20 machine was no longer around anywhere, so it--  
 21 at the time, even when we went over, it was no  
 22 longer there. So you know, any documentation  
 23 that could be in there, and I wouldn't know  
 24 exactly what it was, was lost.  
 25 CHAYTOR, Q.C.:

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1 Q. And six months ago when that notion dawned on  
 2 you because of the request regarding the  
 3 Ventana, did you then pursue that with anyone?  
 4 Did you take it up with Mr. Gulliver, Mr.  
 5 Dyer, anyone else to inquire as to well, do we  
 6 have similar records anywhere, even though the  
 7 computer is not here, do we have these records  
 8 on a disk anywhere or are there hard copies?  
 9 Did you take that up?  
 10 MS. PREDHAM:  
 11 A. Well, I had gone through all that at the time,  
 12 in 2005, with them about records, focusing  
 13 mostly on the DAKO at the time.  
 14 CHAYTOR, Q.C.:  
 15 Q. But you didn't understand--I'm understanding  
 16 you to say you wouldn't have known enough  
 17 about it at the time to ask for those  
 18 particular types of records. So six months  
 19 ago when you're asked for a similar request or  
 20 it's brought to your attention regarding the  
 21 Ventana and then it occurs to you, "well, if  
 22 it exists on this system, what about on the  
 23 old system?" Did you then go and specifically  
 24 ask anyone about do such records exist from  
 25 the DAKO days?

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1 MS. PREDHAM:  
 2 A. Not at that time, no.  
 3 CHAYTOR, Q.C.:  
 4 Q. And have you ever since?  
 5 MS. PREDHAM:  
 6 A. No.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay. Just go back to what you tell and don't  
 9 tell a patient, in terms of any causative  
 10 factors. If it is multiple issues involved  
 11 and we're looking at our swiss cheese and no  
 12 one incident probably in and of itself or one  
 13 factor could have caused the event, but it  
 14 contributed and without it, the event would  
 15 not have occurred. Do you tell then each step  
 16 along the way, so that this happened to you  
 17 because A, B, C, D and unfortunately on the  
 18 particular day that we were dealing with your  
 19 care, all of those holes lined up and we have  
 20 your event. So is that the kind of factual  
 21 information that you would give to the  
 22 patient?  
 23 MS. PREDHAM:  
 24 A. It really depends on what the patient wants to  
 25 hear and how much detail that they want to

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1 have, and sometimes when--in my experience in  
 2 talking to people, the first time you give  
 3 them information and then about six months or  
 4 something, they come back and want some more  
 5 detail, and you know, then it depends on that  
 6 circumstance. You know, I've talked to people  
 7 about, you know, some terrible things and you  
 8 know, some of the contributing factors, they  
 9 seem so futile, you know, like so unfortunate.  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes, okay. So in terms of we just think about  
 12 some of the factors that we've heard about  
 13 certainly in this Inquiry which may have  
 14 contributed, things that Ms. Wegrynowski  
 15 found, things that Dr. Carter noticed, things  
 16 you yourself found, and I'll take you through  
 17 some of that in terms of what you yourself  
 18 were able to ascertain in your investigation,  
 19 and things that Dr. Banerjee found. So taking  
 20 all of those different factors and for  
 21 example, the internal controls or not looking  
 22 at internal controls.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. While that, in and of itself, didn't cause the  
 2 problem, the fact that you have that hole in  
 3 the cheese and if pathologists had been  
 4 checking for the internal controls, could it  
 5 have been picked up earlier -  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. - you know, in 2003, 2004, as opposed to when  
 10 it ultimately is picked up. So in terms of  
 11 that being a hole in the cheese, would that--  
 12 you'd have no hesitation should the patient  
 13 want that kind of detail, you'd have no  
 14 hesitation in disclosing that type of  
 15 information to the patient?  
 16 MS. PREDHAM:  
 17 A. No, no.  
 18 CHAYTOR, Q.C.:  
 19 Q. That these are the issues that not only do we  
 20 think contributed, may have, in fact, caused  
 21 this problem to go undetected for a period of  
 22 time?  
 23 MS. PREDHAM:  
 24 A. Yes, and the circumstances in which I was  
 25 telling people, it was unusual, I was on a

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1 phone talking to people. I was calling the  
 2 people who were confirmed negative, so their  
 3 treatment hadn't changed, you know, they  
 4 stayed the same and, you know, the other thing  
 5 was that when I tell them this, I give them my  
 6 number, my name, and my contact number, and  
 7 all the people who called the confirmed  
 8 negatives would do the same thing, and that if  
 9 they had any questions, they could tell us  
 10 about it, they could call and ask, and, you  
 11 know, it was--you were telling them a lot of  
 12 information at this time, and it's a very  
 13 complicated, you know, thing, and each one was  
 14 so different that--when you were on the phone  
 15 with the people. So the amount of information  
 16 that you're giving them is kind of judged on  
 17 that. It's hard--it was a hard disclosure to  
 18 make because you're on the phone and you don't  
 19 know how much they're understanding what  
 20 you're saying anyway.  
 21 CHAYTOR, Q.C.:  
 22 Q. You had a script, I believe, that you were  
 23 following?  
 24 MS. PREDHAM:  
 25 A. We drafted up a script to kind of stick to,

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1 but you can't really stick to that as you're  
 2 going along. You do get the concepts out and  
 3 it's good to refer to, to make sure you've  
 4 covered everything off.  
 5 CHAYTOR, Q.C.:  
 6 Q. I just want to be clear then, any of the  
 7 patients who did ask you and were interested  
 8 in knowing what happened or what may have  
 9 caused this, your answer to them was, "It  
 10 wasn't any one thing", and at no point did you  
 11 tell anyone it may have been or we have some  
 12 reason to believe these are some of the things  
 13 that may have contributed?  
 14 MS. PREDHAM:  
 15 A. No, I never went in that detail.  
 16 CHAYTOR, Q.C.:  
 17 Q. I'm wondering, I guess, then, Ms. Predham, in  
 18 the spirit of openness and disclosure to the  
 19 patient, why you wouldn't have?  
 20 MS. PREDHAM:  
 21 A. Well, I guess I was just taking the lead from  
 22 talking to them on the phone. It was--you  
 23 know, like I said, in my past experience in  
 24 talking to patients and you give them the  
 25 information, you kind of take the lead on how

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1 much information they want and they need, and  
 2 you give them the opportunity to call you back  
 3 and go through that discussion with them. No  
 4 one had asked for greater detail than that,  
 5 and, you know, that's just the circumstances  
 6 that arose.  
 7 CHAYTOR, Q.C.:  
 8 Q. And so in asking what caused this and  
 9 answering that question, you didn't just tell  
 10 them everything that you knew up to that point  
 11 in time?  
 12 MS. PREDHAM:  
 13 A. Well, I guess, at that point, Ms. Chaytor, if  
 14 you're talking to someone and I'm explaining  
 15 this test to them, and a lot of people didn't  
 16 know that they had this test done, you know,  
 17 so you're--you're explaining that this is an  
 18 ER/PR test, that this was used. You had to  
 19 differentiate the fact that this was not  
 20 anything telling them that they didn't have  
 21 breast cancer or not, that this was not a  
 22 mammogram, this was not the diagnostic test,  
 23 this was the--especially if they were negative  
 24 and confirmed negative, this may not have even  
 25 been in the scope of them disclosing that, so

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1 in that conversation where you're having this  
 2 fact that you had this test, it was negative,  
 3 it came back, you're confirmed negative, so  
 4 everything is the same with you, there's no  
 5 impact on your treatment, and then, you know,  
 6 and having that discussion of again who you  
 7 are, and that you can call back, and that you  
 8 can, of course, call your doctor and if you  
 9 have any questions, call me back. There was a  
 10 lot of information to be giving over the  
 11 phone, and it was also difficult to judge what  
 12 people were taking in because some people just  
 13 said, yes, yes, yes, no questions.  
 14 CHAYTOR, Q.C.:  
 15 Q. But the ones that come back and say, well,  
 16 what happened?  
 17 MS. PREDHAM:  
 18 A. There was very rarely anybody who wanted more  
 19 information than what I had told them.  
 20 CHAYTOR, Q.C.:  
 21 Q. Right, but there were people who asked you  
 22 what happened, and you didn't tell them  
 23 everything that you knew up to the point that  
 24 you're speaking to them?  
 25 MS. PREDHAM:

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1 A. I didn't tell them about fixation, and I  
 2 didn't get into that level of detail.  
 3 CHAYTOR, Q.C.:  
 4 Q. Did you tell them anything that you knew as to  
 5 what may have gone wrong?  
 6 MS. PREDHAM:  
 7 A. I told them that there was not one thing--  
 8 there wasn't one thing that went wrong, there  
 9 was a multiple of things, that we weren't 100  
 10 percent sure what it was, and that we were  
 11 investigating it.  
 12 THE COMMISSIONER:  
 13 Q. Ms. Predham, you referred to the difficulty of  
 14 doing this over the phone. What was your  
 15 position--let me go back further. Were you  
 16 part of the group that decided to do it over  
 17 the phone?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 THE COMMISSIONER:  
 21 Q. And were you in favour of doing it over the  
 22 phone or not, and if you were in favour; why,  
 23 and if not, why?  
 24 MS. PREDHAM:  
 25 A. At the time, I think there was a lot of

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1 logistical problems. When we came to the  
 2 meeting that we were going to disclose to the  
 3 people who were going to be retested, we were  
 4 still talking about a letter, and there was a  
 5 lot of logistical things with the letter, you  
 6 know, the addresses, registered mail, we had  
 7 problems with MCP numbers, you know, this type  
 8 of thing, and I remember at that meeting that  
 9 Dr. Williams said forget it, we're going to  
 10 call people, and just call them, that would be  
 11 easier. In ways it was easier because you  
 12 could actually have that conversation and you  
 13 could--instead of somebody just going to the  
 14 post office and getting a letter with this  
 15 information in it, you could have this  
 16 discussion with them, but, you know, at times  
 17 it was--sometimes it was hard. I had one I  
 18 can remember so distinctly this lady, a  
 19 conversation with her, and she--she had  
 20 cancer, different cancers. Her family had so  
 21 much cancer in it, and she was telling me all  
 22 the different cancers that they had in their  
 23 family, and we had a long discussion about  
 24 ER/PR and how--not how this happened, I don't  
 25 think she ever asked me how this happened, but

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1 she was glad that the results were back, she  
 2 was glad they were the same, and the next  
 3 morning when I walked in my office, the phone  
 4 was ringing and this was her, and she asked me  
 5 if I was telling her that she didn't have  
 6 cancer any more. So my conversation with her  
 7 was at least 45 minutes long and I felt she  
 8 had a very good understanding of what I was  
 9 saying, and then for her to be questioning her  
 10 diagnosis the next morning, then--she was  
 11 probably one of the last ones I was talking to  
 12 that I started really thinking, wow, you know,  
 13 like, I never--she shocked me coming back with  
 14 that question because I didn't expect her to  
 15 misunderstand that.  
 16 CHAYTOR, Q.C.:  
 17 Q. And was she offered to come in and having a  
 18 meeting with people who could explain it to  
 19 her?  
 20 MS. PREDHAM:  
 21 A. Oh, yes, definitely, you know, do you want to  
 22 speak to your physician, do you want--you  
 23 know, she seemed fine after we had that  
 24 conversation, and I think she started second  
 25 guessing it after I hung up because--and maybe

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1 it could have been because we had such a long  
 2 conversation that she kind of got lost in the  
 3 point of why I was calling her. You know,  
 4 that's -  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay. Perhaps we'll go back to P-0057. I  
 7 just want to finish up with this document. On  
 8 page six, and I will have more questions about  
 9 the actual contacting, of course, of the  
 10 patients and how that took place. It says,  
 11 "An occurrence reporting form must be  
 12 completed for all adverse events, hazards,  
 13 incidents, near misses, and sentinel events",  
 14 and for specific details, they're referred to  
 15 the sentinel event policy. "Occurrence  
 16 reports must be submitted to the respective  
 17 manager responsible for the area where the  
 18 occurrence happened. Managers must ensure  
 19 completion of the occurrence reporting form  
 20 and submit it to all appropriate quality and  
 21 clinical safety leader. If further follow up  
 22 is required, the manager must document all  
 23 follow up activities on the occurrence". I  
 24 think this note answers the Commissioner's  
 25 question earlier in terms of employee related

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1 incidents, "The purpose of occurrence  
 2 reporting is to provide a database of clinical  
 3 safety issues and the corrective actions  
 4 taken, promote consistency and timeliness in  
 5 reporting occurrences, facilitate response by  
 6 the Quality and Risk Management Department to  
 7 potential liability, exposure, monitor, track,  
 8 and trend so that high priority areas for  
 9 improvement can be identified and actioned and  
 10 reoccurrence prevented. Use as a tool in the  
 11 improvement of quality of patient client  
 12 resident care, provide opportunities to  
 13 provide feedback, dialogue, and problem  
 14 solving", and, Ms. Predham, I take it in our  
 15 discussion today that this has been basically  
 16 the purpose of occurrence reporting  
 17 throughout?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. There's nothing--even though the policy here  
 22 is new, these are--have always been well  
 23 understood to be the purpose for occurrence  
 24 reporting?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And the idea of having a database of clinical  
 4 safety issues and the corrective actions  
 5 taken, I take it that's going to be improved  
 6 now, and we've discussed that with your  
 7 electronic reporting, and prior to what you  
 8 were doing was keeping any occurrence reports  
 9 that came to your attention, you were keeping  
 10 your own Excel spreadsheets?  
 11 CHAYTOR, Q.C.:  
 12 Q. Right.  
 13 CHAYTOR, Q.C.:  
 14 Q. Of those, and keeping track in that respect as  
 15 best you could?  
 16 MS. PREDHAM:  
 17 A. As best we could.  
 18 CHAYTOR, Q.C.:  
 19 Q. Yes. So even if you hadn't received an actual  
 20 report filled out regarding an occurrence, but  
 21 it came to your attention, and you said, for  
 22 example, earlier in your evidence that if it  
 23 were, you know, a major issue, a big concern,  
 24 you'd know about it, it gets through to you  
 25 fairly quickly.

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. So even if you didn't have the report filled  
 5 out, would it still end up on your spreadsheet  
 6 or in your database?  
 7 MS. PREDHAM:  
 8 A. Probably not in our old system because, like I  
 9 said, the benefit of having it in there for  
 10 any kind of data trending or anything wasn't  
 11 there because it was so cumbersome to work  
 12 with, but we'd certainly have to keep track of  
 13 that and make sure that it gets in there in  
 14 our new system.  
 15 CHAYTOR, Q.C.:  
 16 Q. So any--the only things that ended up in your  
 17 spreadsheet would be things that--or in your  
 18 database as it was, were things that came to  
 19 your attention by way of occurrence reports,  
 20 an actual written occurrence report?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. So anything, even though it may be a major  
 25 occurrence, if there wasn't a form filled out,

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1 it wasn't kept track of in your database?  
 2 MS. PREDHAM:  
 3 A. Well, I'd keep track of that separate. That  
 4 would be, like, you'd have a list of your  
 5 critical occurrences or your sentinel events,  
 6 so you'd keep track of it that way.  
 7 CHAYTOR, Q.C.:  
 8 Q. So there would be a separate list for those?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And I'm wondering did Peggy Dean, and her  
 13 case, was there ever an occurrence report  
 14 filled out?  
 15 MS. PREDHAM:  
 16 A. No.  
 17 CHAYTOR, Q.C.:  
 18 Q. Was she kept track of on your sentinel or  
 19 critical event list?  
 20 MS. PREDHAM:  
 21 A. Well, the whole ER/PR was one whole  
 22 occurrence.  
 23 CHAYTOR, Q.C.:  
 24 Q. But at the time in April when her test was  
 25 repeated and there was a change, and she was

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1 advised of that and her treatment changed, at  
 2 that point in time no occurrence report was  
 3 filled out?  
 4 MS. PREDHAM:  
 5 A. No.  
 6 CHAYTOR, Q.C.:  
 7 Q. It comes to your attention. The first time  
 8 you learn about it is in June, is that  
 9 correct?  
 10 MS. PREDHAM:  
 11 A. I learned about the issue in June. I didn't  
 12 learn about her until July.  
 13 CHAYTOR, Q.C.:  
 14 Q. And at that point in time, does her case get  
 15 put on your list?  
 16 MS. PREDHAM:  
 17 A. Not as a separate--she wasn't a separate  
 18 entity. She was part of -  
 19 CHAYTOR, Q.C.:  
 20 Q. So there was her and several others by that  
 21 point?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And all of their names got placed on your

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1 list?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. And does that list still exist, Ms. Predham?  
 6 MS. PREDHAM:  
 7 A. Well, they wouldn't be out separate by name on  
 8 this list. This would be just like issues.  
 9 So it would just be ER/PR as a whole.  
 10 CHAYTOR, Q.C.:  
 11 Q. So you have a list somewhere where you have  
 12 ER/PR occurs?  
 13 MS. PREDHAM:  
 14 A. Well, I mean, the way it goes is that you  
 15 would have--you know, you'd open up a file and  
 16 then we would have a list of all the current  
 17 files that are open. So at that time, I was  
 18 providing a monthly report to corporate QI, so  
 19 it would be on that list. That's where I  
 20 would take that information, put that in that  
 21 report, and that would go monthly to corporate  
 22 QI.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay, so there's no separate list for those  
 25 critical incidents or major occurrences that

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1 occur that don't otherwise make your database?  
 2 MS. PREDHAM:  
 3 A. No, not--there's not a database list. There's  
 4 our filing system and our list of files, and  
 5 these are our current ones that we're working  
 6 on, these are, you know, the active ones, and  
 7 then there are the inactive ones.  
 8 CHAYTOR, Q.C.:  
 9 Q. And is that--that, you're saying, will not  
 10 continue to be your practice once the  
 11 electronic reporting comes on, everything will  
 12 go into your electronic reporting database?  
 13 MS. PREDHAM:  
 14 A. Yes, and we'll still have--you know, if it's a  
 15 critical occurrence or a large occurrence,  
 16 it's going to have a big file, it's going to  
 17 be bigger than just an occurrence report  
 18 because you're going to have follow up, and  
 19 you're going to be actively involved in that,  
 20 so you're going to have a physical file and  
 21 that will be--and there would be a list of  
 22 those files, but we'll have to ensure that  
 23 it's in the database. So we'll have to fill  
 24 out an occurrence report on it as such to make  
 25 sure that it's in there for trending purposes.

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1 CHAYTOR, Q.C.:  
 2 Q. For trending down the road?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. So at some point before that file is closed  
 7 out or at the time of closing out the file,  
 8 you then put it into your database?  
 9 MS. PREDHAM:  
 10 A. Right, and -  
 11 CHAYTOR, Q.C.:  
 12 Q. If that takes years -  
 13 MS. PREDHAM:  
 14 A. But see, well, the way it is now, and, you  
 15 know, the past couple of months I've kind of  
 16 had to back away from this process, just this  
 17 part, but the part where the quality safety  
 18 leader, the documentation of the follow up and  
 19 all that is a very robust system, and we may  
 20 work out if that's going to be our  
 21 documentation of certain dates and all that,  
 22 so it will be an ongoing thing, that we can  
 23 keep track of things in that.  
 24 CHAYTOR, Q.C.:  
 25 Q. Yes, I'm just thinking in terms of, you know,

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1 having--the whole purpose, as we see here, of  
 2 why you would want to keep a database and a  
 3 complete database, what you're saying the  
 4 practice has been in terms of any major  
 5 incidents or sentinel events, I guess, those  
 6 weren't put into your database until whenever  
 7 down the road the matter was actually  
 8 concluded?  
 9 MS. PREDHAM:  
 10 A. They weren't ever put in the database because  
 11 there wasn't any benefit of putting them  
 12 there. We weren't able to go in and search  
 13 for them. This is the old system. So we  
 14 didn't--it wasn't easily searched or trended,  
 15 but in this one we will have to because we're  
 16 going to have a complete system, it's much  
 17 easier to be searched, and we're going to have  
 18 a numerical outcome rating on it. So, you  
 19 know, we may not--but this is all--we're just  
 20 in developing it now, we're just trying to  
 21 figure out how we're going to utilize that.  
 22 CHAYTOR, Q.C.:  
 23 Q. I guess I'm missing why it wouldn't be  
 24 beneficial to put the major things in your  
 25 database, but it is beneficial to put in more

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1 minor things.

2 MS. PREDHAM:

3 A. Because, I guess, the major ones were all

4 physically--you know, had physical files, were

5 physically separated and we had--we considered

6 them active files, and we had a record of

7 those current active files ongoing, so we kept

8 track of them separately.

9 CHAYTOR, Q.C.:

10 Q. But if it's--if the purpose of having it in

11 one place is for continuity for the next

12 person coming through the door into your

13 office, for the purpose of you while you're

14 there, and everyone else being able to track

15 trends, whether it's quarterly or at the end

16 of the year, wouldn't it be important to have

17 your major occurrences as part of that

18 picture?

19 MS. PREDHAM:

20 A. Well, yes, but that's why we putting the

21 proposal to get this. It was so cumbersome--

22 our old system was so cumbersome to do that,

23 the fact that it was all the same people

24 working along, we hadn't developed that

25 practice, and it was something that we

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1 recognized that we really needed to do that,

2 so that's why we've been working through this.

3 CHAYTOR, Q.C.:

4 Q. So, for example, if you were to put Peggy

5 Dean's case into what you had for your

6 database to say that patient had had IHC

7 testing done, ER/PR, in 2002; retested in

8 2005, and converted, needed a change in

9 treatment, that's the type of information, I

10 take it, that you would capture?

11 MS. PREDHAM:

12 A. Yes.

13 CHAYTOR, Q.C.:

14 Q. And that wasn't done, that wasn't put -

15 MS. PREDHAM:

16 A. No.

17 CHAYTOR, Q.C.:

18 Q. In the database. If we could look at, please,

19 P-0113, and I take it, neither was it done,

20 nor was an occurrence report filled out for

21 the patient after Peggy Dean, nor the next

22 one, nor -

23 MS. PREDHAM:

24 A. No.

25 CHAYTOR, Q.C.:

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1 Q. Nor any of them?

2 MS. PREDHAM:

3 A. No.

4 CHAYTOR, Q.C.:

5 Q. There was never occurrence reports filled out,

6 and that was true for the first, say, five

7 patients?

8 MS. PREDHAM:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. And you would have learned then, I guess, on

12 July 12th--you learned that Ms. Dean's test

13 had actually been repeated back in April. Did

14 you inquire at that point in time why an

15 occurrence report hadn't been filled out?

16 MS. PREDHAM:

17 A. No, I didn't. I guess with all the

18 information I was getting, I didn't inquire.

19 CHAYTOR, Q.C.:

20 Q. Ms. Predham, these are the Dr. Ejeckam memos,

21 which I assume you're familiar with, April

22 4th, 2003. In April of 2003 is the first memo

23 here, and it states--this is going, of course,

24 to pathologists and copied to Barry Dyer and

25 technical staff, "Kindly note that

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1 immunohistochemical stains with the following

2 antibodies", and they're listed, including ER

3 and PR, "have remained unreliable, erratic,

4 and, therefore, unhelpful for diagnostic

5 purposes, and consequently the above staining

6 with these antibodies shall stop forthwith

7 until we can solve the reliability,

8 sensitivity, and specificity of problems.

9 Efforts are underway, and hopefully a solution

10 will be found". Were you or anybody else in

11 the QI Department in 2003 notified of the

12 concerns raised by Dr. Ejeckam?

13 MS. PREDHAM:

14 A. No.

15 CHAYTOR, Q.C.:

16 Q. And is this something that you think should

17 have been brought to the attention of Quality

18 and Risk Management?

19 MS. PREDHAM:

20 A. Yes.

21 CHAYTOR, Q.C.:

22 Q. And have you since made any inquiries as to

23 why that didn't happen?

24 MS. PREDHAM:

25 A. Well, I guess, not the why. I guess, you



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1 know, the fact that the literature indicates  
 2 that occurrence reporting is under reported  
 3 and things don't recognize--people don't  
 4 recognize that something is an occurrence or  
 5 needs to be reported outside of their area,  
 6 then, you know, that--I guess that's the  
 7 reason why. They didn't recognize that it  
 8 should be reported to us. The fact that--I  
 9 did say, yes, that an occurrence report should  
 10 be there, but I guess--and that's with the  
 11 understanding that this is something not a  
 12 usual practice. If this was a usual thing  
 13 that could happen from time to time in the lab  
 14 that there would be erratic staining and they  
 15 would have to suspend that until they fine  
 16 tune something and then they go that up, if  
 17 that's an expected practice in the lab, then,  
 18 no, I wouldn't expect an occurrence report.  
 19 If it was an unexpected thing, then I would  
 20 expect one.  
 21 CHAYTOR, Q.C.:  
 22 Q. And if this memo had landed on your desk back  
 23 in 2003, what if anything would you have done  
 24 or caused to have done?  
 25 MS. PREDHAM:

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1 A. Well the first thing that I would have done  
 2 would be to call Dr. Cook and Mr. Gulliver and  
 3 try to get some understanding of the  
 4 situation. And try to get that, is this  
 5 something that you would expect? Is this  
 6 something that you wouldn't expect? So what's  
 7 the significance of it? And then, of course,  
 8 it would be what would be the impact. So  
 9 because if this had been unreliable erratic  
 10 and unhelpful in the past, what do we need to  
 11 do or what needs to be done. And after I  
 12 talked to them, I'd have to talk to Dr.  
 13 Ejeckam then and, you know, get that sense of  
 14 what was going on.  
 15 CHAYTOR, Q.C.:  
 16 Q. So you would have carried out some inquiries  
 17 and contacted the key people, had this been  
 18 brought to your attention at the time.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And you would have been concerned to identify  
 23 whether or not there is an issue with any  
 24 prior testing that had taken place.  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And would you have expected the fact that the  
 4 concerns that he raises and the fact that it  
 5 was a temporary stoppage of certain stains  
 6 and, well I guess his May 4th memo also  
 7 identifies then in putting ER/PR back a  
 8 number--or he certainly makes a number of  
 9 recommendations in terms of carrying out or  
 10 interpreting the immunostain of ER and PR. So  
 11 his concerns through this memo, the May 2nd  
 12 one, the April 4th, May 2nd and then on into  
 13 the June 19th one and I'll take you to that,  
 14 would you expect that it would appear or be  
 15 mentioned in the Laboratory Medicine Program's  
 16 annual report to the Quality Initiative's  
 17 Committee?  
 18 MS. PREDHAM:  
 19 A. Yes, if it was an unexpected process in the  
 20 lab that occurred, yes, I would expect it.  
 21 CHAYTOR, Q.C.:  
 22 Q. And if it's a process which required that the  
 23 stains be suspended for a period of time  
 24 because, in his opinion, they were unreliable  
 25 erratic and there had been a shut down and he

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1 did whatever else he needed to do before  
 2 bringing it back on line, that's the type of  
 3 thing that Quality Initiatives would expect to  
 4 see in the report from the program.  
 5 MS. PREDHAM:  
 6 A. Yes. Now I just note I never saw this memo  
 7 until, I don't know if it makes any  
 8 difference, May of 2007.  
 9 CHAYTOR, Q.C.:  
 10 Q. Yes, so this memo in and of itself wasn't  
 11 brought to your attention at all in your  
 12 investigation?  
 13 MS. PREDHAM:  
 14 A. No.  
 15 CHAYTOR, Q.C.:  
 16 Q. Ms. Predham, what about the contents of the  
 17 memo? The fact that Dr. Ejeckam said -  
 18 MS. PREDHAM:  
 19 A. I knew that he had suspended staining and I  
 20 had seen the second one, but I never saw this  
 21 one.  
 22 CHAYTOR, Q.C.:  
 23 Q. You saw the second one, the May 4th?  
 24 MS. PREDHAM:  
 25 A. Yes. And the third one, obviously.

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1 CHAYTOR, Q.C.:

2 Q. And who brought the--so you did see the June

3 19th one as well?

4 MS. PREDHAM:

5 A. Yes.

6 CHAYTOR, Q.C.:

7 Q. And who brought the May 4th and the June 19th

8 ones to your attention?

9 MS. PREDHAM:

10 A. The second meeting I had about ER/PR, we

11 talked about the fact that he had suspended

12 staining in 2003 for six weeks at that first

13 meeting that I had in July and the second one

14 I had, I got a copy of the third memo at that.

15 And I can't remember where I acquired the

16 second one, it was somewhere along the way,

17 but I didn't see that one until May, 2007.

18 CHAYTOR, Q.C.:

19 Q. And who gave you the June 19th memo during the

20 July 12th meeting?

21 MS. PREDHAM:

22 A. It was either Mr. Gulliver or Dr. Cook.

23 CHAYTOR, Q.C.:

24 Q. And what was the purpose in giving you that

25 memo?

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1 MS. PREDHAM:

2 A. I guess it was, you know, additional

3 information about what happened. We had

4 talked about the suspension of staining at

5 that first meeting, July 10th, I think, and so

6 that questions were, well, why did they stop,

7 you know, what were more details about that,

8 you know, what was going on. So what happened

9 to, you know, when it restarted, what was the

10 comfort level, you know, that kind of thing.

11 And then at the next meeting then one of them

12 brought the letter.

13 CHAYTOR, Q.C.:

14 Q. So the first meeting you're referring to is

15 June 10th?

16 MS. PREDHAM:

17 A. July.

18 CHAYTOR, Q.C.:

19 Q. July 10th, okay.

20 MS. PREDHAM:

21 A. 10th, yeah, it was Dr. Cook, Mr. Gulliver and

22 Dr. Williams and myself.

23 CHAYTOR, Q.C.:

24 Q. And then you meet again on July 12th and one

25 of them brought you the June 19th memo.

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1 MS. PREDHAM:

2 A. Yes.

3 CHAYTOR, Q.C.:

4 Q. At some point then later, you acquire the

5 next, the May 4th memo.

6 MS. PREDHAM:

7 A. Yes.

8 CHAYTOR, Q.C.:

9 Q. And in May of 2007, how is it that you come

10 into possession of the April 4th, 2003 memo?

11 MS. PREDHAM:

12 A. I think we released them publicly and I got a

13 copy of them then.

14 CHAYTOR, Q.C.:

15 Q. And were you--who at that point in time then

16 gave you the memo, the April 4th memo?

17 MS. PREDHAM:

18 A. Susan Bonnell must have sent it over.

19 CHAYTOR, Q.C.:

20 Q. Okay, and were you surprised, were you

21 surprised by the content or -

22 MS. PREDHAM:

23 A. Well I was a bit concerned because of the

24 listing of the other antibodies.

25 CHAYTOR, Q.C.:

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1 Q. And were you concerned in terms of what was

2 being stated as to the reasons for shutting

3 down the staining of all of those antibodies?

4 MS. PREDHAM:

5 A. Well, I mean, the wording was concern, but I

6 guess at that point I must have heard that

7 that was what he thought at the time or that's

8 why--I must have heard that, I wasn't really

9 surprised by the content of that part, the

10 unreliable, erratic--because I think I must

11 have got that--I think that's the wording in

12 the other memos.

13 CHAYTOR, Q.C.:

14 Q. And so what caused you concern was that this

15 just wasn't ER and PR, there were other stains

16 involved?

17 MS. PREDHAM:

18 A. Well the second one, the detail in the second

19 one only referred to ER/PR.

20 CHAYTOR, Q.C.:

21 Q. Yes.

22 MS. PREDHAM:

23 A. And I didn't realize that there was a listing

24 of other ones that were there.

25 CHAYTOR, Q.C.:

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1 Q. And the June 19th memo is his memo directed  
 2 specifically to Terry Gulliver and in this  
 3 one, he certainly refers to following  
 4 persistent erratic results of immunostains in  
 5 our laboratory. So this one is certainly not  
 6 limited to ER/PR.  
 7 MS. PREDHAM:  
 8 A. But at the time when I got that, I wouldn't  
 9 have realized that there was a lot of other  
 10 immunostains, other than ER/PR. And that was,  
 11 you know, that was my learning curve too, to  
 12 understand that.  
 13 CHAYTOR, Q.C.:  
 14 Q. And in getting it then, the April memo and  
 15 having it spelled out for you that there's six  
 16 other stains, why were you concerned?  
 17 MS. PREDHAM:  
 18 A. Well I didn't know what those stains were for,  
 19 what they were used for and I guess at that  
 20 point in time why we had focused in on ER/PR,  
 21 but what did we do with the other ones.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and did you cause inquiries to be made  
 24 as to what were these stains and what  
 25 happened?

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And what were you told?  
 5 MS. PREDHAM:  
 6 A. They were used in a different way than ER/PR,  
 7 that it was a different--they were one of many  
 8 things that would be used for diagnosis and  
 9 they were utilized in a different way by  
 10 clinicians.  
 11 CHAYTOR, Q.C.:  
 12 Q. And who told you that? Who gave you that  
 13 information?  
 14 MS. PREDHAM:  
 15 A. Well, it would have to have been either Mr.  
 16 Gulliver, Dr. Denic or Dr. Cook, or a  
 17 combination of the three.  
 18 CHAYTOR, Q.C.:  
 19 Q. So while you didn't have the April 4th, 2003  
 20 memo in 2005 when you were looking into this  
 21 matter, did you otherwise ever become advised  
 22 that there may have been other stains involved  
 23 in 2003 that were of concern to Dr. Ejeckam?  
 24 MS. PREDHAM:  
 25 A. I did not understand that, you know, and

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1 whether it was something that I missed that  
 2 was explained to me and I just didn't  
 3 appreciate that, but you know, right from the  
 4 beginning the focus was on ER/PR and I did not  
 5 appreciate the fact that there were other  
 6 ones.  
 7 CHAYTOR, Q.C.:  
 8 Q. So until you received the April 4th, 2003 memo  
 9 in May of 2007, you were unaware of any issue  
 10 with any other stains?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And did you make any inquiries then of anyone  
 15 as to, well, why did you give me the other two  
 16 memos and I haven't seen this particular memo,  
 17 how -  
 18 MS. PREDHAM:  
 19 A. Well, at the time in May, 2007, it was unusual  
 20 times anyway, it was all--there was a lot of  
 21 questions being asked and I did ask that, but  
 22 I don't think I ever got a, you know, I don't  
 23 know if I ever got a clear answer why I didn't  
 24 get that one at the time.  
 25 CHAYTOR, Q.C.:

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1 Q. And who did you ask it of?  
 2 MS. PREDHAM:  
 3 A. Well it would have been Mr. Gulliver and Dr.  
 4 Cook, either one or the other--or both  
 5 provided the letter in the first place.  
 6 CHAYTOR, Q.C.:  
 7 Q. If we could just have a look then at the June  
 8 19th, 2003 memo and he writes, "Following  
 9 persistent erratic results of immunostains in  
 10 our laboratory, I accepted to work closely  
 11 with the technical staff in order to rectify  
 12 this problem, despite the fact that the  
 13 problem seems to have been arrested, the state  
 14 of the immunostain at the General Hospital,  
 15 Department of Laboratory Medicine and  
 16 Pathology is still unsatisfactory." And then  
 17 he lists physical location, the fact that the  
 18 immunohistochemical stain is not just another  
 19 special stain, the staff arrangement in his  
 20 opinion is grossly inadequate and talks about  
 21 dedication of staff and more education in  
 22 essence for the staff. "The volume of  
 23 immunohistochemical procedures continued to  
 24 increase. The present staff performing this  
 25 procedure are doing the best they can." And

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1 he talks about them having many other duties.  
 2 "The fairly good stain we now have is a credit  
 3 to them, but they do not have enough time to  
 4 spare. It is my understanding too that some  
 5 of them have less than two or three years"--  
 6 and he's worried about succession. "Finally,  
 7 it is pertinent to mention that results of  
 8 immunostains are extremely important in  
 9 histopathological diagnosis, especially where  
 10 classification of lymphomas and determination  
 11 of benign or malignancy of certain lesions,  
 12 for example in the prostate biopsies depend on  
 13 crisp, reliable and reproducible staining  
 14 results." So in reading this, Ms. Predham, it  
 15 didn't occur to you that he's talking about  
 16 something besides ER/PR?  
 17 MS. PREDHAM:  
 18 A. Well, I mean, to tell you the truth when I saw  
 19 that memo first, I mean the overall memo, I  
 20 don't think I got into that fine sentence  
 21 there about the prostate biopsies, it probably  
 22 did cross my mind and I have even asked at the  
 23 time if he was talking about the whole thing  
 24 somewhere along the way, but I don't really  
 25 have a memory of it. My focus was always at

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1 that time on ER/PR and there was a lot of  
 2 information in that memo that concerned me.  
 3 So, you know, I can't remember if I picked up  
 4 that it was talking about the prostate  
 5 biopsies or -  
 6 CHAYTOR, Q.C.:  
 7 Q. Or lymphomas.  
 8 MS. PREDHAM:  
 9 A. Yeah.  
 10 CHAYTOR, Q.C.:  
 11 Q. "And diagnosis based on inappropriate  
 12 immunostainer will surely jeopardize patient  
 13 care and may even expose the Health Care  
 14 Corporation of St. John's to litigation;  
 15 therefore, it will be ill advised to operate  
 16 an unreliable and erratic immunohistochemical  
 17 procedure in our laboratory." And I take it  
 18 in terms of things written in this memo that  
 19 caused you, as risk manager, concern, these  
 20 would--this would--your antenna would go up,  
 21 your risk management antenna would go up when  
 22 you read something like that.  
 23 MS. PREDHAM:  
 24 A. Oh I think line two or three, I think it was  
 25 starting to go up when I, you know, right from

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1 the beginning.  
 2 CHAYTOR, Q.C.:  
 3 Q. And so by the time you get to these two  
 4 sentences, what are you thinking?  
 5 MS. PREDHAM:  
 6 A. Okay, well what happened after this memo was  
 7 written and, you know, when you see something  
 8 like this after something has happened, after  
 9 the fact, you know, it's almost like it's  
 10 predicting the future, I mean, that again is  
 11 your worse case scenario, you don't want to  
 12 see that. So you want to say, okay, well  
 13 somebody wrote this two years ago, then what  
 14 did we do? Where is the follow up, where is  
 15 the response?  
 16 CHAYTOR, Q.C.:  
 17 Q. And this memo in particular and you being the  
 18 person to liaise with the insurer and the  
 19 person who is looking after risk management  
 20 for your institution, should this have been  
 21 brought to your attention in 2003?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And did you ask Mr. Gulliver or Dr. Ejeckam or

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1 any of the people who are copied on the memo  
 2 as to why it had not been?  
 3 MS. PREDHAM:  
 4 A. My understanding it wasn't--because they felt  
 5 it was something that they could handle within  
 6 the lab and that the tone of it was more the  
 7 way that Dr. Ejeckam spoke, was that he was,  
 8 you know, he tended to speak into this tone  
 9 more than other people. Over the years, I  
 10 have had instances where people who wanted to  
 11 get, you know, attention, usually attention  
 12 from the risk management department to fix  
 13 something, will speak in this, in this way and  
 14 talk about litigation and risk.  
 15 CHAYTOR, Q.C.:  
 16 Q. Did you meet with Dr. Ejeckam?  
 17 MS. PREDHAM:  
 18 A. No, I didn't.  
 19 CHAYTOR, Q.C.:  
 20 Q. Why not?  
 21 MS. PREDHAM:  
 22 A. In 2005?  
 23 CHAYTOR, Q.C.:  
 24 Q. At any point in time throughout your  
 25 investigation of the matter, did you go speak

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1 to Dr. Ejeckam?  
 2 MS. PREDHAM:  
 3 A. I met with him later on. He went on holidays.  
 4 I think Dr. Cook was going to talk to him  
 5 first and then he went on holidays for four or  
 6 five weeks and in September I think I met with  
 7 him.  
 8 CHAYTOR, Q.C.:  
 9 Q. September of 2005?  
 10 MS. PREDHAM:  
 11 A. I think, it could have been October, somewhere  
 12 in, you know, later on when this was  
 13 progressing.  
 14 CHAYTOR, Q.C.:  
 15 Q. So you're saying in July you didn't meet with  
 16 him, but when he got back from holidays, I met  
 17 with him, and you believe it to be around  
 18 September 2005.  
 19 MS. PREDHAM:  
 20 A. Right.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, and did you find him to speak in an  
 23 exaggerated manner?  
 24 MS. PREDHAM:  
 25 A. Not when he was speaking to me, no.

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1 CHAYTOR, Q.C.:  
 2 Q. And have you met with him or had discussions  
 3 with him since your discussion in September  
 4 2005?  
 5 MS. PREDHAM:  
 6 A. I may have been in a meeting with him there,  
 7 but I never had, you know, a one-on-one  
 8 conversation with him after.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay, and when you met with him in September,  
 11 2005, what did you discuss with him?  
 12 MS. PREDHAM:  
 13 A. We were talking more, he was explaining the  
 14 test and the reading of the slides.  
 15 CHAYTOR, Q.C.:  
 16 Q. I'm sorry?  
 17 MS. PREDHAM:  
 18 A. He was explaining the test and the reading of  
 19 the slide--the interpretation, that part of  
 20 it.  
 21 CHAYTOR, Q.C.:  
 22 Q. Oh, he was explaining the ER/PR test to you.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. Because he was still overseeing the IHC lab at  
 2 that point in time.  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. What about the memo, though, of June 19th,  
 7 2003? Did you ask Dr. Ejeckam, I have this  
 8 memo, what on earth did you mean?  
 9 MS. PREDHAM:  
 10 A. No, actually I didn't at that time because I  
 11 know that Dr. Cook had followed up and Dr.  
 12 Williams had spoken to him about that.  
 13 CHAYTOR, Q.C.:  
 14 Q. And you didn't bring it up with him at all?  
 15 MS. PREDHAM:  
 16 A. No.  
 17 CHAYTOR, Q.C.:  
 18 Q. And so your understanding is that Dr. Cook and  
 19 Dr. Williams had both already followed up with  
 20 Dr. Ejeckam to find out what he meant in June  
 21 of 2003.  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And had that information been relayed back to

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1 you?  
 2 MS. PREDHAM:  
 3 A. Well, the fact that he did have concerns about  
 4 that area, I mean, there were some very  
 5 concrete things that he had in there that were  
 6 addressed by Mr. Gulliver about the physical  
 7 location of the facility, and you know, those  
 8 things that were--they were very concrete  
 9 things and that he didn't like the crispness  
 10 of the staining or whatever the terminology he  
 11 used about the staining and that he stopped  
 12 and wanted to address it.  
 13 CHAYTOR, Q.C.:  
 14 Q. So I just want to be clear, so they came back--  
 15 it was left in their hands to follow up with  
 16 Dr. Ejeckam. And Dr. Cook and Dr. Williams  
 17 came back and told you what Dr. Ejeckam had to  
 18 say or who told you what Dr. Ejeckam had to  
 19 say?  
 20 MS. PREDHAM:  
 21 A. Well they didn't come back to report to me and  
 22 tell me what they did. I just happened to be  
 23 there when they were discussing what Dr.  
 24 Ejeckam had said, you know. I guess it was, I  
 25 mean, you couldn't argue with his, what he was

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1 saying and what he was saying that there was  
 2 issues here and all of that, you couldn't  
 3 argue with that because we were faced with the  
 4 situation. So, I mean, that was what it was.  
 5 CHAYTOR, Q.C.:  
 6 Q. It had come to pass what he -  
 7 MS. PREDHAM:  
 8 A. Exactly, so I mean, there was no arguing--  
 9 there was no debate about that, but the, I  
 10 guess the concern was, was the response to  
 11 this memo and what had taken place and what  
 12 had anybody done and was he satisfied with it  
 13 at that time. And as I understood he was chair  
 14 of the Surgical Pathology Committee and he had  
 15 the ability to go to Dr. Williams with  
 16 concerns that he felt weren't being resolved  
 17 at that level and that he had, in fact, had  
 18 gone forward with a concern about histories on  
 19 -  
 20 CHAYTOR, Q.C.:  
 21 Q. Clinical histories -  
 22 MS. PREDHAM:  
 23 A. On requisitions. But he didn't go forward  
 24 with this issue, so I think that was, that was  
 25 part of the discussion that Dr. Williams had

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1 had with him.  
 2 CHAYTOR, Q.C.:  
 3 Q. And I take it then there was no discussion as  
 4 to whether or not they felt, in fact, Dr.  
 5 Ejeckam was blowing things out of proportion  
 6 or exaggerating in terms of what he had  
 7 written in the memo?  
 8 MS. PREDHAM:  
 9 A. No, we didn't discuss that part at all.  
 10 THE COMMISSIONER:  
 11 Q. Ms. Chaytor, wherever you can find a spot,  
 12 we'll take the luncheon break.  
 13 CHAYTOR, Q.C.:  
 14 Q. And after receiving this memo yourself, what  
 15 did you do with it?  
 16 MS. PREDHAM:  
 17 A. I shared it with Ms. Pilgrim.  
 18 CHAYTOR, Q.C.:  
 19 Q. And did you share it with anyone else?  
 20 MS. PREDHAM:  
 21 A. I sent a copy to our insurance adjustor.  
 22 THE COMMISSIONER:  
 23 Q. When you say "this memo" are we talking about  
 24 the one on the screen now, the June 19th?  
 25 CHAYTOR, Q.C.:

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1 Q. The June 19th, yes.  
 2 THE COMMISSIONER:  
 3 Q. Okay, thank you.  
 4 CHAYTOR, Q.C.:  
 5 Q. And did you do that also for the May 4th one  
 6 as well?  
 7 MS. PREDHAM:  
 8 A. I really can't remember because it was later,  
 9 I got that later on.  
 10 CHAYTOR, Q.C.:  
 11 Q. For the May 2nd, I should say--oh, that was  
 12 April 4th, no, the May 2nd one.  
 13 MS. PREDHAM:  
 14 A. No, the May 2nd one, I can't remember when I  
 15 got that. I know I got it somewhere along the  
 16 way, but I really can't remember.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, but you certainly sent the June 19th one  
 19 on to Ms. Pilgrim and on to HIROC?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. This is a good place, please, Commissioner.  
 24 THE COMMISSIONER:  
 25 Q. All right then, we'll take the luncheon break.

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1 2:15?  
 2 (ADJOURNED FOR LUNCH)  
 3 THE COMMISSIONER:  
 4 Q. Please be seated. Ms. Chaytor.  
 5 CHAYTOR, Q.C.:  
 6 Q. Good afternoon, Commissioner. Good afternoon,  
 7 Ms. Predham. We have a new exhibit this  
 8 afternoon, Commissioner, C-0275, if that could  
 9 be entered please?  
 10 THE COMMISSIONER:  
 11 Q. Entered.  
 12 EXHIBIT ENTERED AND MARKED C-0275  
 13 CHAYTOR, Q.C.:  
 14 Q. And, Registrar, if you could bring up again,  
 15 please, P-0113? These are Dr. Ejeckam's  
 16 memos, Ms. Predham, that we were looking at  
 17 before the break, and in the June 19th, 2003  
 18 memo, which I understand you to say that you  
 19 did have it in July of 2005, this one was the  
 20 first one given to you.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And you said in reading this, I brought you  
 25 specifically to paragraph 6, but you said in

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1 reading down through this, there were things  
 2 that caught your attention and were of concern  
 3 to you. Are there any--if you want to just  
 4 take us through and tell us in reading this at  
 5 that time, what specific things were jumping  
 6 out at you in terms of a risk management  
 7 perspective?  
 8 MS. PREDHAM:  
 9 A. Well I guess, you know, given the  
 10 circumstances of, you know, the discussion  
 11 that we had a couple of days before, you know,  
 12 with the situation and being explained what  
 13 the situation was, so then when you read this,  
 14 even the first line with "Following persistent  
 15 erratic results", you know, that would have me  
 16 concerned. So do you want me to go through -  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes, please, continue on.  
 19 MS. PREDHAM:  
 20 A. Well also going through, I guess, looking at  
 21 it that the physical location was  
 22 unsatisfactory, the haphazard and laissez  
 23 faire approach to it, you know, these types of  
 24 things were, you know, grossly inadequate,  
 25 staff arrangements, all that type of

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1 terminology, of course, would get me  
 2 concerned.  
 3 CHAYTOR, Q.C.:  
 4 Q. Yes. And if I could just take you to this  
 5 part here in terms of "the staff should be a  
 6 problem shooter and that can only materialize  
 7 through understanding of the subject." Were  
 8 those statements of concern to you as well?  
 9 MS. PREDHAM:  
 10 A. Well it was all a concern, I don't know if  
 11 that first time reading through that I would  
 12 have focused in on that as much. I think more  
 13 the ones that I mentioned there and then down  
 14 below, you know, it was, "Do less would be a  
 15 gamble where you may win or lose, this  
 16 obviously will spell disaster." Those are the  
 17 ones that got my attention.  
 18 CHAYTOR, Q.C.:  
 19 Q. Yes, that type of language certainly got your  
 20 attention.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And again, of course, the portions that I  
 25 brought your attention to earlier.

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And if we could just go back then please, or I  
 5 can do that, to the April 4th memo and this  
 6 one wasn't brought to your attention until May  
 7 of 2007, after it became or was going to be  
 8 released to the public, this document. And  
 9 your concern, you said, in having, in  
 10 receiving this then at that time was that it  
 11 spelled out for you that there were, in fact,  
 12 other stains involved?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. Prior to--and none of this, as you've said,  
 17 was brought to your attention or the Quality  
 18 Initiatives Department in 2003.  
 19 MS. PREDHAM:  
 20 A. No.  
 21 CHAYTOR, Q.C.:  
 22 Q. Prior to 2005, was there any issue with  
 23 respect to the Laboratory Medicine Program and  
 24 in particular, the types of issues that are  
 25 dealt with in these memos, the

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1 immunohistochemistry portion of the lab, were  
 2 there any concerns brought to your attention  
 3 or the Quality Initiatives Department's  
 4 attention regarding that aspect of the  
 5 program?  
 6 MS. PREDHAM:  
 7 A. No, and like I said before, I never knew there  
 8 was an immunohistochemistry portion of the  
 9 lab.  
 10 CHAYTOR, Q.C.:  
 11 Q. And what about other areas which may impact on  
 12 the quality of work that the lab could  
 13 produce, for example, were there any issues of  
 14 fixation brought to the attention of yourself  
 15 or the Quality Initiatives Department prior to  
 16 2005?  
 17 MS. PREDHAM:  
 18 A. I can't remember--most of the issues that had  
 19 came forward over the years, I mean, there  
 20 were issues, there's been issues in all areas  
 21 of the organization, but I can't remember one  
 22 that was a global issue with fixation, it was  
 23 more a one-off, if there was anything--seems  
 24 that there's a memory of something to do with  
 25 fixation, but it was more a one-off type of

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1 situation. But that's just a vague memory.  
 2 There have been issues over the years, but you  
 3 know, we had addressed those, but none that,  
 4 like I said, I didn't realize there was an  
 5 immunohistochemical service.  
 6 CHAYTOR, Q.C.:  
 7 Q. There had been what kinds of issues over the  
 8 years?  
 9 MS. PREDHAM:  
 10 A. Well there was issues with, you know, there  
 11 were adverse events or occurrences that  
 12 happened.  
 13 CHAYTOR, Q.C.:  
 14 Q. Within the lab, you mean?  
 15 MS. PREDHAM:  
 16 A. Within the lab. Some of those could have bene  
 17 a delay in reports, you know, that happened,  
 18 misinterpretation of or incorrect diagnosis,  
 19 you know, those types of things that have  
 20 occurred from time to time throughout the  
 21 years.  
 22 CHAYTOR, Q.C.:  
 23 Q. Yes, but anything in looking back on it and in  
 24 your investigation of the issue, anything that  
 25 would be relevant to what ultimately unfolds

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1 in the ER/PR issue?  
 2 MS. PREDHAM:  
 3 A. No.  
 4 CHAYTOR, Q.C.:  
 5 Q. And the one-off that you mentioned of  
 6 fixation, did that--when you say "one-off"  
 7 when this then arises and you become aware of  
 8 an issue regarding fixation, did you have  
 9 cause to go back and look at that situation?  
 10 MS. PREDHAM:  
 11 A. No, I only have a vague memory of that, but it  
 12 was, it was not this type of issue. It was  
 13 something that was, you know, left too long,  
 14 like an individual thing was left too long  
 15 somewhere or something. It was an individual  
 16 event that was unusual for the time.  
 17 CHAYTOR, Q.C.:  
 18 Q. Yes, like a specimen left too long in either  
 19 the OR or -  
 20 MS. PREDHAM:  
 21 A. Yes, something like that, it was, you know, it  
 22 was a mistake at that time. It was--it  
 23 wasn't, you know, handled in the proper way  
 24 and it was an unusual, you know, not the  
 25 typical process and that's just the--I'd have

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1 to go back, it's only a vague memory.  
 2 CHAYTOR, Q.C.:  
 3 Q. And in terms of any other issues regarding the  
 4 Laboratory Medicine Program over the years,  
 5 was there ever any issue in terms of tissue  
 6 processing brought to your attention or to the  
 7 attention of Quality Initiatives?  
 8 MS. PREDHAM:  
 9 A. No, not to that--the only other one up to that  
 10 point about tissue processing was one time a  
 11 sample had, they're in little baskets when  
 12 they get embedded and the tissue had come out  
 13 of the basket and it was just to go through  
 14 the process of how that happened, but that  
 15 was, again, I think the little plastic basket  
 16 that it was in had cracked or something and  
 17 the tissue had come out of it.  
 18 CHAYTOR, Q.C.:  
 19 Q. So nothing else in terms of the histology  
 20 portion of the lab brought to your attention?  
 21 MS. PREDHAM:  
 22 A. No.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay. And if we could look, please, at P-  
 25 1853? And before we do that, though, I should

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1 ask you if we could go back to P-0113 please,  
 2 sorry. Is there anything in terms of this  
 3 April 4th, 2003 memo in the language that Dr.  
 4 Ejeckam used about the stains being  
 5 unreliable, erratic and unhelpful for  
 6 diagnostic purposes, this--and I guess also  
 7 the memo that I just showed you of June 19th,  
 8 that type of language and in your career of  
 9 risk management, have you ever been presented  
 10 with documents, memos, letters of this nature?  
 11 I know you said there are times when people  
 12 will say, you know, we're going to be sued if  
 13 you don't take certain measures, but in terms  
 14 of the language that we see here used by Dr.  
 15 Ejeckam, have you ever had a similar  
 16 experience where there's that type of strong  
 17 language used?  
 18 MS. PREDHAM:  
 19 A. Strong language, not necessarily those same  
 20 words because, of course, the circumstances  
 21 would have been different, but yes, I've had  
 22 memos that have had strong language in it.  
 23 CHAYTOR, Q.C.:  
 24 Q. And what do you do in those circumstances?  
 25 MS. PREDHAM:



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1 A. Well you'd have to go back to the leadership  
 2 team and get some context around it and then  
 3 talk to the person involved and see what the  
 4 situation is.  
 5 CHAYTOR, Q.C.:  
 6 Q. And I guess you evaluate the risk and see  
 7 whether or not the language is warranted?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay, I'm sorry, if we could go then please to  
 12 P-1853? And Ms. Predham, these are answers to  
 13 interrogatories that you provided and I  
 14 understand there are two different sets of  
 15 answers that you've provided and this  
 16 particular set is in answer to interrogatories  
 17 of the Plaintiff dated June 14th, 2007 and  
 18 this, of course, is in the Class Action  
 19 lawsuit. And those answers are sworn to on  
 20 August 3rd, 2007.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And in coming up with the answers in this  
 25 document, did you have assistance from other

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1 people?  
 2 MS. PREDHAM:  
 3 A. Yes, we had--I had to arrange for a conference  
 4 call with Mr. Gulliver, Dr. Cook, Dr. Denic,  
 5 Dr. Williams, Dr. Laing. I have to think--  
 6 that's about all of them, and to help me  
 7 answer them because I couldn't answer them on  
 8 my own.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay, and so it does say that, "You make oath  
 11 and say to the best of my knowledge,  
 12 information, and belief, based on my review of  
 13 the medical literature and my experiences and  
 14 interactions with oncologists, pathologists,  
 15 and other medical professionals on the topic  
 16 of breast cancer and breast cancer testing as  
 17 follows".  
 18 MS. PREDHAM:  
 19 A. And I couldn't sign it without that proviso  
 20 being there.  
 21 CHAYTOR, Q.C.:  
 22 Q. Yes, okay, and if we could just look at page  
 23 two, paragraph four, and it deals with the  
 24 memorandum of Dr. Ejeckam, June 19th, 2003,  
 25 "As to the memorandum written by Dr. Ejeckam

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1 on June 19th, 2003, and appended hereto, was  
 2 consideration given to retesting breast cancer  
 3 specimens for ER/PR status which had been  
 4 tested during the period when Dr. Ejeckam  
 5 considered that results had been erratic;  
 6 whose responsibility was it to consider and  
 7 recommend or not recommend retesting; where in  
 8 2003 did ultimate authority to make such a  
 9 decision lie; where did it lie in 2005; who  
 10 recommended retesting, and who decided that  
 11 the retesting would be done", and the answer  
 12 that you provided is, "I have no direct  
 13 knowledge of Dr. Ejeckam's memo of June 19th,  
 14 2003, and the circumstances surrounding same.  
 15 My response is based solely on the information  
 16 that has been provided to me". Who amongst  
 17 the individuals you mentioned would have then  
 18 given you the information to enable you to be  
 19 able to respond?  
 20 MS. PREDHAM:  
 21 A. Dr. Cook and Mr. Gulliver.  
 22 CHAYTOR, Q.C.:  
 23 Q. "I understand that the changes referenced in  
 24 Dr. Ejeckam's memo of June 19th, 2003, were  
 25 seen as an enhancement and improvement of the

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1 stains as a quality improvement activity and  
 2 as part of the development/enhancement of the  
 3 continuing quality assurance program". So  
 4 where did that information come from?  
 5 MS. PREDHAM:  
 6 A. That would have been Mr. Gulliver.  
 7 CHAYTOR, Q.C.:  
 8 Q. And what is the--in 2003, what continuing  
 9 quality assurance program did you understand  
 10 existed in the laboratory medicine program and  
 11 specifically the section of the lab dealing  
 12 with IHC?  
 13 MS. PREDHAM:  
 14 A. The quality assurance that they had in 2003 up  
 15 to 2005 was limited, but was based on the  
 16 feedback of the pathologists. So when the  
 17 stains were done, they relied on the feedback  
 18 of the pathologists back to the technologists,  
 19 and that was considered their quality  
 20 assurance program.  
 21 CHAYTOR, Q.C.:  
 22 Q. And in 2007, August, 2007, when you're  
 23 swearing these answers to the interrogatories,  
 24 did you have any concern in stating that this  
 25 was done as part of the development and

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1 enhancement of the continuing quality  
 2 assurance program?  
 3 MS. PREDHAM:  
 4 A. That was their understanding of the quality  
 5 assurance program at that time, that was what,  
 6 you know, they had established as a quality  
 7 assurance program, and that's all I could say  
 8 to that. At 2003, that's what they considered  
 9 that to be.  
 10 CHAYTOR, Q.C.:  
 11 Q. "I do not believe the retesting, the ER and PR  
 12 results was discussed or considered at that  
 13 time", and who would have given you that  
 14 information?  
 15 MS. PREDHAM:  
 16 A. Well, both Dr. Cook and Mr. Gulliver for that.  
 17 CHAYTOR, Q.C.:  
 18 Q. "Unlike in 2005, I do not believe that there  
 19 was a conversion or sentinel event", and what  
 20 information would you have had available to  
 21 you to be able in August, 2007, to swear to  
 22 that as being an accurate statement?  
 23 MS. PREDHAM:  
 24 A. That was the information that I had, that  
 25 there hadn't been at that time a conversion.

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1 CHAYTOR, Q.C.:  
 2 Q. And do you still believe that to be the truth?  
 3 MS. PREDHAM:  
 4 A. No, I know that's not true now.  
 5 CHAYTOR, Q.C.:  
 6 Q. And when did you learn the difference?  
 7 MS. PREDHAM:  
 8 A. I think it was when the patients were  
 9 testifying here.  
 10 CHAYTOR, Q.C.:  
 11 Q. So that was the first time that you became  
 12 aware was here through this process in 2008  
 13 that, in fact, there had been conversions?  
 14 MS. PREDHAM:  
 15 A. The names--I didn't recognize the names of  
 16 some of the patients or family members that  
 17 you had on the witness list, so then when  
 18 checking into it, I discovered that there were  
 19 retests.  
 20 CHAYTOR, Q.C.:  
 21 Q. And did you go back and make any inquiries of  
 22 Mr. Gulliver or Dr. Cook, knowing that you had  
 23 given a sworn statement otherwise, to say how  
 24 that could have been overlooked or not brought  
 25 to your attention earlier?

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1 MS. PREDHAM:  
 2 A. Well, I didn't go because I made a sworn  
 3 statement. I went because I was -  
 4 CHAYTOR, Q.C.:  
 5 Q. Out of concern.  
 6 MS. PREDHAM:  
 7 A. I was concerned that this information was  
 8 there.  
 9 CHAYTOR, Q.C.:  
 10 Q. Fair enough.  
 11 MS. PREDHAM:  
 12 A. So--and I'm not sure that either one of those  
 13 gentlemen were aware of it at that point in  
 14 time. It seemed to be something that the  
 15 clinicians involved, either the pathologists  
 16 or the oncologists involved, were aware of,  
 17 but did not appreciate the information at the  
 18 time.  
 19 CHAYTOR, Q.C.:  
 20 Q. So Mr. Gulliver, in having reviewed the  
 21 pathology reports for purpose of retesting,  
 22 didn't indicate to you whether he had, in  
 23 fact, come across cases that had been retested  
 24 previously?  
 25 MS. PREDHAM:

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1 A. No, I--and actually it never even crossed my  
 2 mind that he would have seen that, you know,  
 3 going through that.  
 4 CHAYTOR, Q.C.:  
 5 Q. And when you spoke to him about it in 2008, he  
 6 didn't indicate that to be the case, that in  
 7 fact he had seen tests that had been retested  
 8 in the past?  
 9 MS. PREDHAM:  
 10 A. I don't remember him mentioning that to me.  
 11 I'm sure I would have remembered it.  
 12 CHAYTOR, Q.C.:  
 13 Q. And you specifically went to him with that  
 14 question?  
 15 MS. PREDHAM:  
 16 A. We had that discussion with--you know, with  
 17 Dr. Denic as well, you know, so it was a  
 18 general discussion.  
 19 CHAYTOR, Q.C.:  
 20 Q. And if we could bring up then, please, C-175.  
 21 I'm just going to show you--these are  
 22 pathology reports that we've redacted, Ms.  
 23 Predham, and this particular one, I'll take  
 24 you to the ER/PR portion, and you'll see that  
 25 it is 2003, so the time period that's referred

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1 to in your answers to the interrogatories, and  
 2 the first addendum is May 6th, 2003, and when  
 3 compared to controls, the specimen is negative  
 4 for HER2/neu, ER and PR, and then May 9th,  
 5 2003, the ER and PR were repeated due to  
 6 quality assurance issues. The repeated stains  
 7 shows the following; ER positive in 80 percent  
 8 of the cells, PR positive in 10 percent of the  
 9 cells. I take it, this wasn't--this  
 10 particular incident, there was no occurrence  
 11 report filed with Quality Initiatives  
 12 regarding this particular change?  
 13 MS. PREDHAM:  
 14 A. And--well, really in this circumstance, I  
 15 would not have even expected as such because  
 16 the quick turnaround time between the 6th and  
 17 the 9th, you know, quality assurance is there  
 18 to catch problems, so if they did--if there  
 19 was some reason they tested that in that short  
 20 period of time, that would be an expected, you  
 21 know, program, it got caught and got retested  
 22 and it went on. So I wouldn't necessarily  
 23 expect an occurrence report.  
 24 CHAYTOR, Q.C.:  
 25 Q. Even if the results changed?

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1 MS. PREDHAM:  
 2 A. Well, see when--in things that happen in an  
 3 organization, you have a double check on--for  
 4 instance, take the pharmacy. So the  
 5 pharmacist does up the medication, it goes  
 6 through, and before it leaves the pharmacy,  
 7 there's a double check, and if that person  
 8 doing the double check catches a mistake or a  
 9 mislabelling or some kind of error, there  
 10 isn't an occurrence report filled out because  
 11 that's why the double check is there. There's  
 12 an expectation that there's going to be a  
 13 problem, so you put the double check in to  
 14 catch it. So that wouldn't be necessarily a  
 15 basis of an occurrence report. The pharmacy  
 16 keeps track of it themselves, and then goes  
 17 back and looks to see if there's patterns and  
 18 all that, but there's not an occurrence report  
 19 as such. If it gets outside the pharmacy and  
 20 gets past the double check, then it's an  
 21 occurrence report.  
 22 CHAYTOR, Q.C.:  
 23 Q. So we don't--so this is not considered a near  
 24 miss?  
 25 MS. PREDHAM:

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1 A. It could be. It depends on what the quality  
 2 assurance program is here. If the quality  
 3 assurance program going through, if the  
 4 pathologist sees this and says, oh, look,  
 5 there's a problem here with the lab, you're  
 6 going to have to redo this, that's--I would  
 7 expect that that is the normal thing, that is  
 8 the normal practice that would go through and  
 9 they would have to reissue that. Be that as  
 10 it may, it depends on what--you know, I'd have  
 11 to talk to Dr. Cook or Dr. Denic and say, you  
 12 know, but I could see that this could be -  
 13 CHAYTOR, Q.C.:  
 14 Q. But how would you even get an opportunity to  
 15 do that if it's not brought to your attention?  
 16 MS. PREDHAM:  
 17 A. But that's--I guess that's the whole thing of  
 18 having those discussions. The example I gave  
 19 with pharmacy, that was discussions that we  
 20 had with the pharmacy leadership and with the  
 21 managers in there, that this is their process,  
 22 what is an occurrence, when does an occurrence  
 23 report get filled out.  
 24 CHAYTOR, Q.C.:  
 25 Q. Ms. Predham, and bear in mind that the service

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1 had been shut down and brought back on line by  
 2 Dr. Ejeckam, according to his memo, on May  
 3 4th, 2003, and so this is now May 6th, 2003,  
 4 and again May 9th, 2003, and I just want to be  
 5 clear in terms of when an occurrence report--  
 6 so would that in the background as well in  
 7 terms of--and I realize your department is not  
 8 aware that the service had been shut down, but  
 9 the pathologists certainly would have been  
 10 aware of that?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. Pathologists would have been aware that the  
 15 service is shut down, and then we have within  
 16 the three day period, different results. In  
 17 that context, would you expect that an  
 18 occurrence report would be brought to your  
 19 attention?  
 20 MS. PREDHAM:  
 21 A. And I guess I'm trying to give you, like, a  
 22 bit of supposition here. It would be nice to  
 23 get an occurrence report on this, but I can  
 24 see that there would be reasons why it  
 25 wouldn't be done.

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1 CHAYTOR, Q.C.:

2 Q. And, Ms. Predham, it's also--this is entered

3 and signed out, and it replaces the pervious

4 report, and there is a phone call apparently

5 made to the Cancer Clinic regarding this. So,

6 of course, it could be that the patient has

7 already been treated on the basis of the first

8 signed out report.

9 MS. PREDHAM:

10 A. That is a fair observation. If the

11 pathologist signed it out, then for some

12 reason there would have been a reason to go

13 back, so you're right, it would have been more

14 of an occurrence than a basic quality

15 assurance activity.

16 CHAYTOR, Q.C.:

17 Q. So in that circumstance, it would follow,

18 looking at your policy on the reporting of

19 occurrences, that this should have had an

20 occurrence report filed?

21 MS. PREDHAM:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. If we could have C-228, please. I'll take you

25 to the second page of this document, Ms.

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1 Predham--actually, it's probably the fourth

2 page of the document, and this one you'll see

3 that the original test is March 17th, 2003,

4 estrogen and progesterone immunoperoxidase

5 method, ER occasional positive less than 1

6 percent, PR 15 percent positivity, and in

7 brackets [no controls available], and then

8 Addendum Two was entered May 28th, 2003, as

9 requested, repeat estrogen and progesterone

10 receptors by immunoperoxidase staining, and

11 estrogen is 40 percent positive, progesterone

12 is 73 percent positivity, and again both of

13 these are signed out; one in March, and one in

14 May, by the pathologist, and there's a

15 conversion. This wasn't brought to your

16 attention at the time. Would you have

17 expected that there would be an occurrence

18 report filed for this particular incident?

19 MS. PREDHAM:

20 A. Yes.

21 CHAYTOR, Q.C.:

22 Q. If we could have, please, C-174. This one

23 there's even a longer period of time between

24 the two tests. I'll just take you to the last

25 page, I believe, of the document, page four,

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1 and in this one the original test is done

2 August 29th, 2002, and immunohistochemical

3 staining for progesterone is positive in

4 approximately 15 percent of lesional cells,

5 and immunohistochemical staining for estrogen

6 receptors is negative, and you'll see again

7 that's August 29th, 2002. Then it's repeated

8 and entered on the chart, June 11th, 2003, at

9 the request of Dr. Zaidi, immunohistochemical

10 staining for estrogen and progesterone

11 receptors has been repeated. Estrogen

12 receptors show faint positivity in

13 approximately 10 to 15 percent of lesional

14 cells, progesterone receptors are

15 unequivocally positive in approximately 75

16 percent of lesional cells, and again would you

17 expect that to have been brought to your

18 attention by way of an occurrence report?

19 MS. PREDHAM:

20 A. Yes.

21 CHAYTOR, Q.C.:

22 Q. Okay, and Ms. Predham, those that I've shown

23 you, this one being June 11th, 2003, and the

24 first one that I showed you was the repeat was

25 May 28th, 2003--I'm sorry, May 9th, 2003, and

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1 then it was May 28th, 2003, and then the third

2 repeat is June 11th, 2003. So there were

3 three incidents of conversions in

4 approximately a one month period in 2003. Had

5 that been brought to your attention, would

6 that have triggered to you a trend?

7 MS. PREDHAM:

8 A. Oh, definitely. I mean, it was something that

9 would require investigation.

10 CHAYTOR, Q.C.:

11 Q. And at that point in time then, Ms. Predham,

12 what would you have done or caused to have

13 been done?

14 MS. PREDHAM:

15 A. I mean, you'd have to look and, you know,

16 investigate it to see what was going on, see

17 what to expect in the processes, see what was

18 out there in the literature, see what we're

19 doing, see what--you know, you'd have to go

20 through almost everything that we did in the

21 fall or summer of 2005.

22 CHAYTOR, Q.C.:

23 Q. Yes, okay. Ms. Predham, in looking at this

24 last case, and of course, this one is in

25 August of 2002 and we now know, of course,

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1 what ends up being referred to as the sentinel  
 2 case was in 2002, summer of 2002 as well, and  
 3 this particular case was then repeated less  
 4 than a year later, in June of 2003. Would  
 5 there be any distinction drawn between Peggy  
 6 Deane's case and how you responded to Peggy  
 7 Deane's case and how this is in this  
 8 particular case?  
 9 MS. PREDHAM:  
 10 A. You mean would I respond the same?  
 11 CHAYTOR, Q.C.:  
 12 Q. Yes.  
 13 MS. PREDHAM:  
 14 A. Definitely, you know, the same type of issue.  
 15 I don't know if--the one other category with  
 16 her is that they were all--the type of cancer  
 17 that she had was expected to be all positive,  
 18 so that was another criteria, but that  
 19 wouldn't have made neither here nor there.  
 20 You'd still have to investigate it.  
 21 CHAYTOR, Q.C.:  
 22 Q. If we could have then, please, P-0030? This  
 23 is a meeting of the Corporate Quality  
 24 Initiatives Committee and we've spoke a little  
 25 bit about that this morning, this committee,

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1 January 27th, 2005. Ms. Pilgrim is the  
 2 chairperson and you are a member on the  
 3 committee. Just actually, the document I  
 4 wanted to refer you to is further along. It's  
 5 not this particular one. It's on page 50, I  
 6 believe, Registrar. Okay, take you back to  
 7 the first page of these particular minutes.  
 8 Here we go. Yes, sorry.  
 9 This particular meeting is September  
 10 22nd, 2005. Ms. Pilgrim is still the  
 11 chairperson, and you are in attendance at the  
 12 meeting. Page 50, laboratory--tell you where  
 13 this shows up, for your reference.  
 14 MS. PREDHAM:  
 15 A. I think that's my monthly report.  
 16 CHAYTOR, Q.C.:  
 17 Q. Report by Director of Quality and Systems  
 18 Improvement. So this is you making this  
 19 report?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and the following was highlighted from  
 24 the June, July and August 2005 report. "A  
 25 patient initially tested in 2002 for ER/PR and

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1 was found to be negative was retested and was  
 2 strongly positive. Four other patients were  
 3 retested and all now tested positive. A full  
 4 review of services, including an external  
 5 review of the immunohistochemistry service, is  
 6 being conducted. All ER/PR testing and  
 7 supporting by this lab is presently on hold  
 8 awaiting outcome of review." And I take it  
 9 that's Ms. Deane's case that's being referred  
 10 to and then the four that followed?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And "occurrence reporting is now completely up  
 15 to date. First quarter reports for 2005 have  
 16 been sent out to program areas. A multiple  
 17 year report for 1998 through to 2005 was  
 18 reviewed, transcription errors," and it goes  
 19 on from there. So I take it, at this meeting,  
 20 you would also bring forward any occurrence  
 21 reports that are relevant?  
 22 MS. PREDHAM:  
 23 A. Well, right there, what I was referring to,  
 24 the end of the previous year, our occurrence  
 25 reporting database had crashed, I guess, for a

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1 better term, and we couldn't utilize it any  
 2 more. So our data entry of the occurrence  
 3 reports was behind. So Information Management  
 4 had to rebuild our database and then we were  
 5 behind a lot of data entry. So it was at this  
 6 point in time we had caught up to where we  
 7 were.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and Ms. Predham, at this point in time,  
 10 now it's September 22nd, 2005, and I will take  
 11 you back chronologically in time, but if you  
 12 had known in 2003 of the three cases that I've  
 13 pointed out to you within approximate one  
 14 month period, I take it there would be no  
 15 different reaction than what we see here  
 16 following on the index patient and the four  
 17 other patients, and a full review would have  
 18 been conducted in 2003?  
 19 MS. PREDHAM:  
 20 A. Yes, and I think that highlights the  
 21 importance of the people who are doing the  
 22 work valuing occurrence reporting, because if  
 23 they know of things and they don't tell  
 24 anybody about it, really can't, as an  
 25 organization, you can't do anything about it.

1 CHAYTOR, Q.C.:

2 Q. Yes, and if we could have page 60 please, in

3 this document? And this is continuing on with

4 Corporate Quality Initiatives Committee and

5 this particular meeting is November 24th,

6 2005. Again, Ms. Pilgrim is chairing and you

7 are in attendance, and on page 60, there is

8 reference to Baker Norton report, and under

9 standing agenda items, patient safety plan,

10 "Ms. Predham requested direction on the

11 patient safety plan initiative, i.e. whether

12 it should continue or be put on hold. Members

13 felt the initiative has gained momentum and

14 currently there is an opportunity to begin and

15 grow in stable program level areas. Ms.

16 Pilgrim will seek input on a direction from

17 Louise Jones and Pamela Elliott." And I'm

18 just wondering, you're seeking direction at

19 this point in time as to the patient safety

20 plan initiative. What was that initiative and

21 what was ultimately decided to do?

22 MS. PREDHAM:

23 A. Well, that was the initiative that I mentioned

24 this morning that we had gotten the money, the

25 funding for to launch that. So that was in

1 would be the difference in what you were doing

2 under the clinical safety plan within Eastern

3 Health, and which was now a bigger

4 organization, and the continuing operation of

5 what you had developed for Health Care Corp?

6 MS. PREDHAM:

7 A. Well, there were only certain areas that

8 stayed stable, weren't affected by the

9 amalgamation. So that would be like the

10 surgery program in the St. John's hospitals or

11 the medicine program or critical care. So the

12 clinical programs in the St. John's hospitals

13 really were not affected directly by the

14 amalgamation in Eastern Health.

15 THE COMMISSIONER:

16 Q. Um-hm.

17 MS. PREDHAM:

18 A. Whereas all the other ones were, you know,

19 like support programs. Pharmacy became

20 regionalized. We became regionalized. We

21 also are now in community health, long-term

22 care, so the same patient safety plan wouldn't

23 be applicable to those areas. So I guess that

24 was the consideration that the stable areas,

25 the ones that weren't affected, could carry on

1 the old Health Care Corporation patient safety

2 plan. We had a lot of structure put in place

3 around that and I really didn't know what to

4 do with it now, when we got to this point,

5 because we were Eastern Health. There were--

6 it was the opportunity to keep it in areas

7 that hadn't changed fundamentally, and I think

8 what was decided was that there would be a

9 broader clinical safety plan brought

10 throughout the whole organization. The

11 directions, the initiatives that, you know,

12 the stable and, I guess, that's the area, the

13 program level that didn't change, like in St.

14 John's hospitals that were previous part of

15 the Health Care Corporation could keep those

16 going because they had set up patient safety

17 committees within their program and they could

18 keep their initiatives going, but that the

19 overall work on the patient safety plan would

20 be on hold while the clinical safety plan for

21 Eastern Health would subsume it, I guess.

22 CHAYTOR, Q.C.:

23 Q. Okay, and if we could have, please, P-1905?

24 THE COMMISSIONER:

25 Q. Sorry, I'm not sure I followed that. What

1 in that direction that they were doing, but

2 organizationally, we needed to have a new

3 plan.

4 THE COMMISSIONER:

5 Q. And was it intended that once the new plan

6 came in, it would replace the one from Health

7 Care Corporation in those areas that had been

8 stable?

9 MS. PREDHAM:

10 A. Yes.

11 THE COMMISSIONER:

12 Q. Oh, okay, thanks.

13 MS. PREDHAM:

14 A. And that being said, like all the other legacy

15 boards would have had their own direction on

16 patient safety anyway. So it was to, you

17 know, consolidate all that.

18 THE COMMISSIONER:

19 Q. Okay, yes, now I understand. Thank you.

20 CHAYTOR, Q.C.:

21 Q. Thank you, Registrar, it's P-1905, and these

22 are notes of a meeting, Laboratory Medicine

23 Program, February 27th, 2004, and it's Doctors

24 Cook, Williams and Mr. Gulliver in attendance.

25 I'll just bring you then to page two. This is

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1 dealing with pathology technical  
 2 consolidation. "We are still awaiting--we are  
 3 still waiting on final recommendation from  
 4 Heather Predham, QI, in regards to risk  
 5 management concerns expressed by St. Clare's  
 6 pathologists." And there's also follow up  
 7 then on this issue at P-1912, please? And  
 8 again, this is another meeting of the  
 9 Laboratory Medicine Program, the next month,  
 10 March 26th, 2004, and at page three, there's  
 11 reference again to pathology technical  
 12 consolidation. "Some discussion in regards to  
 13 the final assessment from Heather Predham in  
 14 regards to risk management issues and concerns  
 15 brought forward from St. Clare's pathologists.  
 16 Ms. Predham, in her analysis, did not find any  
 17 risk management issues related to the  
 18 pathologist consolidation, and Dr. Williams  
 19 will arrange a meeting with George Tilley,  
 20 Terry and Dr. Cook to make a final decision."  
 21 Ms. Predham, what do you recall about the  
 22 issue of consolidation of pathology services  
 23 to one site and your involvement in analysing  
 24 that situation?  
 25 MS. PREDHAM:

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1 A. This was an issue that the lab had planned to  
 2 consolidate the pathology over on one site,  
 3 which they had done with microbiology and had  
 4 done with another division of their lab, which  
 5 escapes me right now, biochemistry. And so  
 6 now it came to here and some concerns were  
 7 raised, from a risk management perspective.  
 8 So I met with the pathologists at St. Clare's,  
 9 Dr. Cook, Mr. Dyer and Mr. Gulliver, and went  
 10 through their concerns and there mostly were  
 11 concerns regarding transport between sites and  
 12 that type of issue.  
 13 CHAYTOR, Q.C.:  
 14 Q. Transport of specimens, I take it?  
 15 MS. PREDHAM:  
 16 A. Yes, and I guess the turnaround times, any  
 17 effect on that, from a risk management  
 18 perspective. They had given me names of  
 19 different hospitals, some which were  
 20 consolidated and were multi-site and  
 21 consolidated services and some which weren't.  
 22 So I checked with those areas. I checked with  
 23 HIROC to see if they had any risk management  
 24 concerns concerning consolidation only. It  
 25 was limited to that part, changing the

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1 practice of that. And I couldn't find any  
 2 evidence, but I did recommend that they--you  
 3 know, I couldn't find any evidence of any risk  
 4 management concerns regarding consolidation or  
 5 not consolidation.  
 6 CHAYTOR, Q.C.:  
 7 Q. And at the time when you were asked--I take it  
 8 they invited your input on this?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And did St. Clare's have particular concerns?  
 13 It says there were concerns brought forward  
 14 from St. Clare's pathologists.  
 15 MS. PREDHAM:  
 16 A. It was mostly concerned around the turnaround  
 17 time, because surgery would still carry on at  
 18 St. Clare's and then, of course, it would have  
 19 to get over to the Health Sciences. So it was  
 20 mostly transport of specimens in a timely way.  
 21 CHAYTOR, Q.C.:  
 22 Q. I guess the specimens then coming from St.  
 23 Clare's to the Health Sciences and then being  
 24 processed and the blocks or slides shipped  
 25 back to St. Clare's for interpretation by the

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1 pathologists there?  
 2 MS. PREDHAM:  
 3 A. No, I believe all the pathology services would  
 4 be over at the Health Sciences, the  
 5 pathologists would be over there as well.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, so the whole site. So it's not just the  
 8 technical consolidation at this point in time.  
 9 This was--your review was for the entire  
 10 pathology should be consolidated on one site?  
 11 MS. PREDHAM:  
 12 A. That's my memory.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and in your discussions with the  
 15 laboratory medical program around this issue,  
 16 did you detect any problems between--  
 17 communication problems or management problems  
 18 between the clinical side of the program and  
 19 the technical side of the program? So between  
 20 the clinical chief and the program director,  
 21 were there any issues that you were able to  
 22 sense between the two branches of the program?  
 23 MS. PREDHAM:  
 24 A. I didn't sense any communication issues, but  
 25 there was--I guess it was the driver, from Mr.

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1 Gulliver and Mr. Dyer's side, they had, you  
 2 know, the budgetary pressures. I think the  
 3 Hay report had been before that. So it was  
 4 all this of trying to keep things under  
 5 budget, trying to--this is a cost savings to  
 6 do that and then it was the concerns on the  
 7 pathologists side about the quality--I mean,  
 8 not saying that Mr. Gulliver and Mr. Dyer  
 9 weren't concerned about quality of service,  
 10 but you know, that there, but they had that  
 11 extra pressure that the pathologists didn't  
 12 have. So there was that, I guess, a different  
 13 viewpoint as opposed to--but not communication  
 14 issues. They were very clear on where they  
 15 were coming from.  
 16 CHAYTOR, Q.C.:  
 17 Q. On communicating with one another their  
 18 positions?  
 19 MS. PREDHAM:  
 20 A. Yes, yeah.  
 21 CHAYTOR, Q.C.:  
 22 Q. Yes, okay, and what about any other--did you  
 23 detect any other problem then in terms of any  
 24 divide, as such, between the management and  
 25 clinical sides of the program?

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1 MS. PREDHAM:  
 2 A. Just that aspect of it. I mean, it was a  
 3 difference of opinion, but also, you know,  
 4 there was the--I got a sense that there was  
 5 the--you know, they didn't want to see St.  
 6 Clare's--from the pathologists, they wanted  
 7 the services to stay at St. Clare's, and you  
 8 know, this is the way it is and it's been like  
 9 that and they're content with that and the  
 10 service is good like that, but we've been  
 11 through a lot of that over the years, you  
 12 know, so that was--and that was a valid  
 13 concern that people had.  
 14 CHAYTOR, Q.C.:  
 15 Q. I want to take you then to the--and I take it  
 16 there's now going to be the consolidation of  
 17 the pathology service to the Health Science.  
 18 Have you been involved in the issue since?  
 19 MS. PREDHAM:  
 20 A. No, that was my only involvement.  
 21 CHAYTOR, Q.C.:  
 22 Q. That's your only involvement, okay. I'll take  
 23 you then to the ER/PR issue and you told us  
 24 that in June of 2005, there was a brief  
 25 comment made by Dr. Cook just to give you a

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1 heads up.  
 2 MS. PREDHAM:  
 3 A. Dr. Williams.  
 4 CHAYTOR, Q.C.:  
 5 Q. Dr. Williams, sorry, and then you have a  
 6 meeting on July 12th.  
 7 MS. PREDHAM:  
 8 A. July 10th, I think.  
 9 CHAYTOR, Q.C.:  
 10 Q. July 10th, I'm sorry, yes, July 10th, and  
 11 again July 12th. And on July 10th, that's  
 12 when you first learn about Peggy Deane's case,  
 13 is it?  
 14 MS. PREDHAM:  
 15 A. Yes, and I never knew her name, you know.  
 16 CHAYTOR, Q.C.:  
 17 Q. Right, okay, and what were you told in that  
 18 meeting? What were you told about Peggy  
 19 Deane's case, the index case, in that meeting?  
 20 MS. PREDHAM:  
 21 A. I can't really remember exactly what I was  
 22 told in that meeting. I know a couple of days  
 23 later when we had the larger meeting with the  
 24 oncologists and the surgeons, we went through  
 25 that story again. So it's pretty hard to

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1 differentiate what I was told one or the  
 2 other, but -  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay, that's fine, yes. I'm just wondering  
 5 what--yes, what in fact were you told, whether  
 6 it's July 10th, July 12th.  
 7 MS. PREDHAM:  
 8 A. Yeah, because it's hard to differentiate  
 9 between one and other.  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes.  
 12 MS. PREDHAM:  
 13 A. Basically that this lady was diagnosed in  
 14 2002. I believe it's with lobular type breast  
 15 cancer. She was ER/PR negative and her  
 16 disease progressed. She was very ill at this  
 17 time, and her oncologist wanted to see whether  
 18 or not there was anything that could be done,  
 19 anything else that was available, and had sent  
 20 the chart or a synopsis of the chart to an  
 21 oncologist at Sloan-Kettering in the States  
 22 and who said basically, you know, you've done  
 23 everything available. However, it's highly  
 24 unusual that this lady would be ER/PR negative  
 25 with this diagnosis. You should probably get



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1 her retested. So then she was, and she did  
 2 convert. She went from negative to strongly  
 3 positive and that caused some discussion. I  
 4 guess that was discussed in a broader sense.  
 5 So they brought that to Dr. Cook's attention  
 6 and they retested several others, which had  
 7 converted as well.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and in being told about the contact with  
 10 the United States, were you told that it was  
 11 Sloan Kettering?  
 12 MS. PREDHAM:  
 13 A. Definitely by later that week. I don't know  
 14 if I was told that immediately, but definitely  
 15 it was Sloan Kettering was later that week.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, and were you told anything in terms of  
 18 any research or review that may have taken  
 19 place at Sloan Kettering?  
 20 MS. PREDHAM:  
 21 A. Well, when they questioned that, they did say  
 22 that, you know, they were just about to  
 23 publish an article and in fact, they were  
 24 going to--they weren't even going to do ER/PR  
 25 on I think it's lobular cancer right now

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1 because they considered them all positive.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay, and who was telling you this, in terms  
 4 of what's happening at Sloan Kettering?  
 5 MS. PREDHAM:  
 6 A. My memory is that it was Dr. McCarthy, but it  
 7 might be Dr. Laing, but that's my memory is  
 8 that it was Dr. McCarthy.  
 9 CHAYTOR, Q.C.:  
 10 Q. And by the time you're brought in and involved  
 11 in this on July 10th, were you made aware of  
 12 any other tests that had been repeated and  
 13 converted, other than the index case?  
 14 MS. PREDHAM:  
 15 A. I think they had only done the five or it may  
 16 have been--they did two groups after that, and  
 17 it may have been the first group. I'm not  
 18 sure if the results were back on that first  
 19 group or not then.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay. There had been a meeting in mid May,  
 22 May 17th, 2005 on this. Were you aware that  
 23 meeting had taken place?  
 24 MS. PREDHAM:  
 25 A. No, not until at this time.

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1 CHAYTOR, Q.C.:  
 2 Q. I'm sorry, which time?  
 3 MS. PREDHAM:  
 4 A. Not until in July.  
 5 CHAYTOR, Q.C.:  
 6 Q. In July, okay, and there's correspondence from  
 7 Dr. Cook to Dr. Williams, May 24th, 2005, and  
 8 perhaps we could just bring that up. It's P-  
 9 0324. And when you met then in July, I'll  
 10 just show you this correspondence and bring  
 11 you down through. Does this look familiar to  
 12 you?  
 13 MS. PREDHAM:  
 14 A. Oh yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And when would you have first seen this  
 17 correspondence?  
 18 MS. PREDHAM:  
 19 A. It would have been after that meeting I had  
 20 with Dr. Williams in June. I'm thinking--I  
 21 don't remember when he actually gave it to me,  
 22 but I'm thinking he must have given it to me  
 23 at that time or shortly after, because there's  
 24 no date stamp from our department on it, and  
 25 if it had come--if he had sent it in the mail

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1 or faxed it, it would have been date stamped  
 2 by our department, but it only has his date  
 3 stamp on it. So I'm thinking he probably gave  
 4 it to me.  
 5 CHAYTOR, Q.C.:  
 6 Q. So in between him mentioning it to you in June  
 7 and then -  
 8 MS. PREDHAM:  
 9 A. The meeting in July.  
 10 CHAYTOR, Q.C.:  
 11 Q. - the meeting in July, you would have come in  
 12 receipt of this?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and of course, then this would have  
 17 referred to the May 17th meeting and it talks  
 18 a little bit about what receptor status  
 19 influences, in terms of treatment, and then it  
 20 refers to "in early 2003, Dr. Ejeckam, our  
 21 point man for immunoperoxidase testing at the  
 22 General Hospital site, discontinued testing of  
 23 the ER and PR receptors for a six-week period.  
 24 A memo was circulated to all pathologists  
 25 across the province stating this. The

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1 technique was temporarily halted because of  
 2 erratic staining, which required readjustments  
 3 of titration and staining times. Once Dr.  
 4 Ejeckam felt confident in the reliability of  
 5 the staining, the test was reintroduced."  
 6 And then "at the conclusion of the May  
 7 17th meeting, it was decided to retest all  
 8 negative ERs and PRs for the year 2002 and  
 9 possibly 2001. I have no idea at this point  
 10 in time, knowing whether these are a few  
 11 isolated cases or whether we are dealing with  
 12 a much bigger issue. For now, we have agreed  
 13 if there is a receptor conversion that the  
 14 oncologists would inform the patient that we  
 15 have retested the ER and PR receptors under  
 16 our newer more sensitive technique. However,  
 17 if it is identified that we have a much more  
 18 significant conversion factor problem,  
 19 involving many patients, we would need to seek  
 20 advice and guidance from QI on how best to  
 21 disclose this information, as this involves  
 22 breast cancer patients across the province."  
 23 And then, in closing, there is a plan set  
 24 out including establishing an external  
 25 proficiency testing, establishing a separate

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1 immunoperoxidase service, the training of the  
 2 technologists in a major immuno referral lab  
 3 that has a well-established quality control  
 4 and troubleshooting program and appropriate  
 5 CME funding for the technologists.  
 6 So when you received this then sometime  
 7 between June and your meeting of July 10th,  
 8 2005, did this cause you any more concern than  
 9 the comment that had been made by Dr. Williams  
 10 originally in terms of not knowing if it's  
 11 going to be a big issue or not?  
 12 MS. PREDHAM:  
 13 A. Well, I was concerned, but then, you know, I  
 14 mean, Dr. Cook also referred to it that he  
 15 didn't know if this was just--I can't remember  
 16 his wording now, towards the end, if this was  
 17 a big issue or he has no idea at that point in  
 18 time whether these are a few isolated cases or  
 19 a much bigger issue. So I had to take it on  
 20 face value that I had to wait until we found  
 21 out.  
 22 CHAYTOR, Q.C.:  
 23 Q. But they're going to be retesting all their  
 24 negatives for 2002 and possibly 2001?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. So you still though, at this point in time,  
 4 sat it out and waited and didn't notify the  
 5 insurer, for example, or take any other  
 6 measures yourself in terms of looking into  
 7 this?  
 8 MS. PREDHAM:  
 9 A. No.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay, and the issue here in terms of what  
 12 would be communicated to the patients, "for  
 13 now, we have agreed that if there is a  
 14 receptor conversion that the oncologists would  
 15 inform the patient that we have retested the  
 16 ER and PR receptors under the newer more  
 17 sensitive technique." Did that cause you any  
 18 concern when you read it?  
 19 MS. PREDHAM:  
 20 A. No, I did note it, that they were doing that,  
 21 and that's an appropriate thing.  
 22 CHAYTOR, Q.C.:  
 23 Q. So is this your marks here?  
 24 MS. PREDHAM:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. Okay, and this is your handwriting?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, and so when you received the document,  
 7 you wrote on here, "did we make  
 8 determination?" Is that what that says?  
 9 MS. PREDHAM:  
 10 A. Yes, I think I'm wondering--I wasn't clear  
 11 here at the time. It said "interpretation of  
 12 these stains were made by those pathologists  
 13 who were assigned the cases. The stains were  
 14 also circulated to pathologists across the  
 15 province according to which lab the cases  
 16 originated from." So I wasn't clear whether  
 17 or not we read the slides or if the  
 18 pathologist outside did so.  
 19 CHAYTOR, Q.C.:  
 20 Q. So who did the interpretation is what you were  
 21 querying?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. In the time period mentioned.

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1 MS. PREDHAM:  
 2 A. Usually when I get a document like this and I  
 3 read it, I ask questions to myself just for  
 4 later.  
 5 CHAYTOR, Q.C.:  
 6 Q. Yes, and I take it then you went back and  
 7 asked those questions of the appropriate  
 8 individuals?  
 9 MS. PREDHAM:  
 10 A. In July, when we met.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay, and -  
 13 MS. PREDHAM:  
 14 A. And that one you're highlighting now, that  
 15 would have been a note that I had made when we  
 16 met in July.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay. So you wrote "came in September 2002."  
 19 MS. PREDHAM:  
 20 A. That was Dr. Ejeckam came in September.  
 21 CHAYTOR, Q.C.:  
 22 Q. You're talking about Dr. Ejeckam, okay. And  
 23 you have memory specific--you have good memory  
 24 enough to be able to say when you even made  
 25 the comments that are written here?

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1 MS. PREDHAM:  
 2 A. Oh, I can--I distinctly remember this, yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. Yes, okay. And over here, you write "why was  
 5 it looked in the past?" Is that what it says?  
 6 MS. PREDHAM:  
 7 A. I guess it's did we go back. Did we look at  
 8 anything before that.  
 9 CHAYTOR, Q.C.:  
 10 Q. And saying why did he shut down the testing?  
 11 Is that what you're asking?  
 12 MS. PREDHAM:  
 13 A. Yes, yeah.  
 14 CHAYTOR, Q.C.:  
 15 Q. And again, those questions would have been  
 16 posed by you to whom and when?  
 17 MS. PREDHAM:  
 18 A. Well, that was just when I was reading  
 19 through. That was just so I'd remember. When  
 20 I read it, when I went to a meeting, these are  
 21 things that I wanted to ask.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and so then did you bring this up with--  
 24 at your meeting on July 10th?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And you asked those questions then of Doctors  
 4 Cook and Mr. Gulliver?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And controls, what does it say here?  
 9 MS. PREDHAM:  
 10 A. "Controls go through all the same process, but  
 11 they are optimally fixed tissue."  
 12 CHAYTOR, Q.C.:  
 13 Q. And what is that referring to?  
 14 MS. PREDHAM:  
 15 A. I guess I must have asked about or been told  
 16 about the control process, the controls that  
 17 are run during this issue.  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, and when would this comment have been  
 20 made?  
 21 MS. PREDHAM:  
 22 A. It would have been made at--usually when I'm  
 23 asking myself questions, for some reason, I  
 24 write them down on this side and then when  
 25 I've got other issues or I'm making notes, I

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1 put them down this side.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay. So usually that's--and that's how  
 4 you're able to remember that too, or it helps  
 5 in your memory. So these over here would be  
 6 notes made -  
 7 MS. PREDHAM:  
 8 A. Before the meeting.  
 9 CHAYTOR, Q.C.:  
 10 Q. - and it's probably different ink too, if we  
 11 had the originals, we'd see.  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. But this is beforehand and these are questions  
 16 or information that's being given to you  
 17 during the meeting of July 10th?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. And so the idea that "controls go through the  
 22 same process, but they are optimally fixed  
 23 tissue," who in the meeting would have told  
 24 you that?  
 25 MS. PREDHAM:

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1 A. Mr. Gulliver, I would assume. I can't  
 2 distinctly remember who told me that, but Mr.  
 3 Gulliver usually told me about the controls  
 4 and that.  
 5 CHAYTOR, Q.C.:  
 6 Q. So was there a concern expressed in this  
 7 meeting that the patients tissues may be other  
 8 than optimally fixed?  
 9 MS. PREDHAM:  
 10 A. No, not that they would be anything other than  
 11 optimally fixed, but that the controls were  
 12 set aside as being optimally fixed. I guess  
 13 that was what I was taking away from it.  
 14 CHAYTOR, Q.C.:  
 15 Q. And I think that's all the comments that you  
 16 made then on this particular document. So  
 17 perhaps then you can take us to the July 10th  
 18 meeting and what else you recall about that  
 19 meeting.  
 20 MS. PREDHAM:  
 21 A. Well, Mr. Gulliver took us through--or Dr.  
 22 Cook took us through the issue, and I guess  
 23 most of the content of what we discussed here,  
 24 and Mr. Gulliver described the test, the fact  
 25 that we had DAKO and that we had Ventana, and

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1 we went through that process.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay. So Mr. Gulliver described to you the  
 4 DAKO days and the use of the DAKO machine, and  
 5 I take it then the difference in bringing on  
 6 the Ventana?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. There was discussion about Dr. Ejeckam and  
 11 what happened in 2003?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And what did Dr. Cook contribute to the  
 16 discussion?  
 17 MS. PREDHAM:  
 18 A. Well, I guess his was, you know, what he had  
 19 learned talking to the oncologists, and what  
 20 we had planned to do, the process of what we  
 21 had sent already off, his communication across  
 22 the province, and then it was, you know, the  
 23 fact that we were going to have to talk to the  
 24 surgeons and the oncologists, and also we came  
 25 up with a list of things that we had to do or

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1 that had to be done that we needed more  
 2 information on.  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay, and was it following this meeting or the  
 5 July 12th meeting that you contacted the  
 6 insurer, contacted Ray Walsh?  
 7 MS. PREDHAM:  
 8 A. I think it was after the last meeting.  
 9 CHAYTOR, Q.C.:  
 10 Q. The second meeting?  
 11 MS. PREDHAM:  
 12 A. The second meeting.  
 13 CHAYTOR, Q.C.:  
 14 Q. So then at the July 12th meeting, who attends  
 15 that?  
 16 MS. PREDHAM:  
 17 A. I think we had two meetings that day. One was  
 18 with Dr. Cook, Mr. Gulliver, and Dr. Williams  
 19 and myself, and then the next one was a larger  
 20 group of oncologists and surgeons; Dr. Laing,  
 21 Dr. McCarthy, Dr. Gardiner, Dr. Kwan, Dr.  
 22 Felix.  
 23 CHAYTOR, Q.C.:  
 24 Q. And perhaps then we could look at P-2940. I'm  
 25 sorry, let's try 925, P-0925. These are notes

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1 of Dr. Williams, and on page--I believe it's  
 2 three of these--no, page two, July 12th, 2005.  
 3 MS. PREDHAM:  
 4 A. Okay.  
 5 CHAYTOR, Q.C.:  
 6 Q. And this is Dr. Cook, Ms. Predham, Mr.  
 7 Gulliver, and Dr. Williams. So is this the  
 8 first meeting you would have had?  
 9 MS. PREDHAM:  
 10 A. This must have been the first meeting, so it  
 11 was July 12th, not the 10th.  
 12 CHAYTOR, Q.C.:  
 13 Q. Not the 10th. So July 12th?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. Was the first meeting you have?  
 18 MS. PREDHAM:  
 19 A. I remember because it was--I can remember the--  
 20 --Mr. Gulliver, I can distinctly remember how  
 21 he saw the Ventana System at the Montreal  
 22 Jewish Hospital and then they brought it in in  
 23 January, 2004. So for him to be telling us  
 24 that, it was that initial meeting I went to.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, so this says there was follow up on  
 2 status by testing ER/PR receptors, but this is  
 3 the first time you've been brought in to this?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, and prior to 2004, there's the  
 8 discussion of the DAKO testing procedure,  
 9 which you recall having been discussed, and  
 10 there was a system of positive controls;  
 11 October, 2003, visiting the Ventana System at  
 12 Montreal Jewish; January, 2004, Ventana System  
 13 purchased, training commenced. So you  
 14 remember, I guess, this was Mr. Gulliver  
 15 speaking to this?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. And they had pulled all the cases in  
 20 September, 2001, to review findings and  
 21 retests. There was an issue of erratic  
 22 staining in early 2003 and testing pulled for  
 23 six weeks. Titration times and staining times  
 24 were adjusted. Tests sent out for six weeks  
 25 to other labs. So at the time that's what I

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1 take it you would have been told that testing  
 2 was sent out?  
 3 MS. PREDHAM:  
 4 A. Yes, I think we understand now that they just  
 5 put a hold on the testing at that time.  
 6 CHAYTOR, Q.C.:  
 7 Q. Yes, and this issue here for breast tissue  
 8 samples should be in formalin for 48 to 72  
 9 hours, controls are in formalin for optimal  
 10 time. So there appears in the July 12th  
 11 meeting there was some discussion about  
 12 fixation. Do you recall that?  
 13 MS. PREDHAM:  
 14 A. No, it doesn't stand out. It may have been  
 15 discussed, but it doesn't stand out right now.  
 16 CHAYTOR, Q.C.:  
 17 Q. And it does refer to first being alerted when  
 18 patient was seen in USA. "An oncologist there  
 19 felt patient testing should have been positive  
 20 for ER/PR, and on retesting here it was.  
 21 Ventana takes the human factor out of the  
 22 equation". Who do you recall making that  
 23 statement?  
 24 MS. PREDHAM:  
 25 A. It would have been Mr. Gulliver.

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1 CHAYTOR, Q.C.:  
 2 Q. And the decision coming out of the July 12th  
 3 meeting is to test all samples of living  
 4 patients, what are positive rates for  
 5 infiltrating lobular and ductal cancer, and  
 6 what did you understand the reason would be  
 7 for looking at positivity rates for those two  
 8 types of cancer?  
 9 MS. PREDHAM:  
 10 A. Well--and I believe it's lobular. I may be  
 11 mistaken, but -  
 12 CHAYTOR, Q.C.:  
 13 Q. Yes.  
 14 MS. PREDHAM:  
 15 A. But the information that we had gotten in this  
 16 story of what happened was that comment by  
 17 Sloan-Kettering that all lobulars should be  
 18 100 percent positive, so, you know, okay,  
 19 let's look at ours and see what our positivity  
 20 rate is for that.  
 21 CHAYTOR, Q.C.:  
 22 Q. And was that after being told to you, or were  
 23 you aware of that by this point in time as to  
 24 what Sloan-Kettering had said?  
 25 MS. PREDHAM:

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1 A. I must have been told that--I guess Dr. Cook  
 2 must have told me at that time or given us a  
 3 background of it.  
 4 CHAYTOR, Q.C.:  
 5 Q. And who made this suggestion to look at our  
 6 positivity rates?  
 7 MS. PREDHAM:  
 8 A. It may have been me, but I guess it was a  
 9 consensus between the four of us.  
 10 CHAYTOR, Q.C.:  
 11 Q. And then it says, "Look at our rate of  
 12 positivity by year". Who would have suggested  
 13 that?  
 14 MS. PREDHAM:  
 15 A. The same thing, I'm not sure exactly who, but  
 16 it would have been the consensus of the four  
 17 of us.  
 18 CHAYTOR, Q.C.:  
 19 Q. And what would the purpose in doing that be?  
 20 MS. PREDHAM:  
 21 A. Well, there was some discussion that there is  
 22 an established positivity rate for ER/PR, and  
 23 I can remember the problem being so many  
 24 pathologists reading that, you know, without  
 25 going to one person, you would really not see-

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1 -a pathologist would not identify that, you  
 2 know, that they're getting more negatives than  
 3 they should be, and I do remember clearly the  
 4 discussion that if you had--say, if it was  
 5 like a 90 percent lobular positivity, and you  
 6 had--you know, if you were a pathologist out  
 7 of town and you don't get a lot of breast  
 8 cancer and you had one that was negative, you  
 9 wouldn't even think twice at it because you  
 10 don't see that many of them. So it would take  
 11 a few of those for you to even start  
 12 questioning it. It was that -  
 13 CHAYTOR, Q.C.:  
 14 Q. Did you understand, though--had you been told  
 15 that Sloan-Kettering weren't even going to  
 16 bother testing for ER/PR for infiltrating  
 17 lobulars any more because they assumed they  
 18 were all positive?  
 19 MS. PREDHAM:  
 20 A. I don't know if I was told that they weren't  
 21 even going to test any more. I don't know,  
 22 that might have been later, but I do know that  
 23 they said they should have been positive as  
 24 almost all--that was the first message I think  
 25 I got, almost all of that diagnosis were

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1 positive.  
 2 CHAYTOR, Q.C.:  
 3 Q. And at some point in time, did you understand  
 4 them to be saying that all, not almost all,  
 5 but all were positive?  
 6 MS. PREDHAM:  
 7 A. That was my understanding, yeah.  
 8 CHAYTOR, Q.C.:  
 9 Q. And you got that from the oncologist, either  
 10 Dr. McCarthy or Dr. Laing?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And in terms of--so in your trying to figure  
 15 out then by testing or checking out the  
 16 positivity rates whether or not that would  
 17 have been a useful exercise over the years, is  
 18 that what you were trying to determine, well,  
 19 maybe if we'd been checking our positivity  
 20 rates, we could have picked up on this  
 21 earlier, is that your thinking?  
 22 MS. PREDHAM:  
 23 A. No, no, it was--at that point in time, it was,  
 24 you know, how are we doing, do we have a  
 25 problem in the past, did we have a problem,

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1 was our positivity rate within the established  
 2 range all these years, or did we have too many  
 3 negatives.  
 4 CHAYTOR, Q.C.:  
 5 Q. And I guess, though, by July 12th the decision  
 6 is made that you're going to test all living--  
 7 the samples of all living patients. So a  
 8 determination as to whether or not you had a  
 9 problem was going to come out at the  
 10 retesting. So I'm just wondering why--what  
 11 would be the benefit at the same time of  
 12 looking at your positivity rates when you have  
 13 a big undertaking ahead of you, in any event,  
 14 to get all these samples together, identify  
 15 the patients, and start the retesting? What's  
 16 the additional benefit in looking at  
 17 positivity rates?  
 18 MS. PREDHAM:  
 19 A. Well, I remember thinking--you know, our  
 20 thought at the time, it could focus our  
 21 activities, you know, to a certain area, but,  
 22 you know, you're making a very valid point  
 23 that we decided to test all samples, but I  
 24 guess that was the intent is that it could  
 25 focus our activities on one or two years or,

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1 you know -  
 2 CHAYTOR, Q.C.:  
 3 Q. So if you were off in any given year, then you  
 4 could probably zone in and concentrate on that  
 5 particular time period?  
 6 MS. PREDHAM:  
 7 A. Yeah.  
 8 CHAYTOR, Q.C.:  
 9 Q. And we understand that this continued, the  
 10 exercise to track the positivity rates  
 11 continued on and Mr. Gulliver has given  
 12 evidence about his involvement in that, and  
 13 did you have--other than perhaps being the  
 14 person to suggest it initially, did you have  
 15 any further involvement in the tracking of  
 16 positivity rates or the collection of that  
 17 data?  
 18 MS. PREDHAM:  
 19 A. No, just the--I saw the results, but I didn't-  
 20 -I wasn't involved in getting them.  
 21 CHAYTOR, Q.C.:  
 22 Q. So you would be provided the results?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. And what was the purpose in giving you the  
 2 results?  
 3 MS. PREDHAM:  
 4 A. Well, I guess just--we were all part of that.  
 5 One of the other things here, and it's noted  
 6 up there, is that you have--the Ventana here  
 7 we were told was ten times more sensitive. So  
 8 if it is more sensitive, then you were going  
 9 to expect conversions, you know, if you went  
 10 back and retested. That was my thinking at  
 11 the time, so if you've got positivity rates  
 12 that were in a norm, you know, that this is  
 13 the range and this was okay, now you'd have  
 14 new technology and were going back, well,  
 15 then, you know, you could see whether or not  
 16 that's the reason for conversions as opposed  
 17 to, you know, there was a problem and we had  
 18 too many negatives at the time.  
 19 CHAYTOR, Q.C.:  
 20 Q. And I take it this comment about the Ventana  
 21 System being ten times more sensitive, that's  
 22 Mr. Gulliver was providing that information?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 THE COMMISSIONER:

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1 Q. The Ventana was more sensitive than what?  
 2 MS. PREDHAM:  
 3 A. Than the DAKO machine.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay.  
 6 MS. PREDHAM:  
 7 A. The DAKO System or process.  
 8 CHAYTOR, Q.C.:  
 9 Q. And he's attributing that, according to the  
 10 comment written here, to the company having  
 11 said that?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. In terms of getting the positivity rates, that  
 16 information, what did you then do with the  
 17 information when it was passed to you? Did  
 18 you pass it along to anyone else?  
 19 MS. PREDHAM:  
 20 A. I'm not--well, see the positivity rates were  
 21 circulated to all of us in the group.  
 22 CHAYTOR, Q.C.:  
 23 Q. Yes.  
 24 MS. PREDHAM:  
 25 A. So other than probably discussing it in our

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1 department, I don't think I was sharing it  
 2 with anybody else because they were all there  
 3 around the table.  
 4 CHAYTOR, Q.C.:  
 5 Q. And did you share it externally to anyone  
 6 outside of Eastern Health?  
 7 MS. PREDHAM:  
 8 A. I don't recall.  
 9 CHAYTOR, Q.C.:  
 10 Q. For example, in terms of keeping the insurer  
 11 up to date, would you have passed that  
 12 information along to the insurer?  
 13 MS. PREDHAM:  
 14 A. I may have, but I don't recall. I may have  
 15 just said our positivity rates, or, you know--  
 16 I don't recall saying, oh, look, I have this,  
 17 I must send this over.  
 18 CHAYTOR, Q.C.:  
 19 Q. And if we could look, please, at P-2940, and  
 20 we understand these to be your own handwritten  
 21 notes, Ms. Predham?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And on page three, you have written on the

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1 top, "Dr. W. Dr. C. Terry and me", and -  
 2 MS. PREDHAM:  
 3 A. This would have been the second meeting. The  
 4 one you had up first would have been that July  
 5 12th, and this would have been the one after.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, so this would be the one after, being  
 8 July 14th?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. So you had two meetings. You had another  
 13 meeting--wait now, let me be clear, because  
 14 you thought you had two meetings on the same  
 15 day, July 12th, is that right?  
 16 MS. PREDHAM:  
 17 A. July 12th, we met, that was the first meeting,  
 18 and then later that week we had a meeting with  
 19 just the four of us, and I thought it was the  
 20 same day later that evening that we met with  
 21 the surgeons and the oncologists. Now it may  
 22 have been the day after, but I thought it was  
 23 the same day.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, all right, so you don't believe this to

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1 be the notes from the July 12th meeting?  
 2 MS. PREDHAM:  
 3 A. No, it definitely wasn't.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay.  
 6 MS. PREDHAM:  
 7 A. Because I didn't get Dr. Ejeckam's memo until  
 8 we had the second meeting.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay, and to the best of your recollection, if  
 11 the first occurred July 12th, the second one  
 12 occurred when?  
 13 MS. PREDHAM:  
 14 A. July 14th, I think.  
 15 CHAYTOR, Q.C.:  
 16 Q. Now July 14th, we know was the meeting with a  
 17 larger group of people. You would have met  
 18 with the oncologists on that day.  
 19 MS. PREDHAM:  
 20 A. So this would have been earlier that day.  
 21 CHAYTOR, Q.C.:  
 22 Q. So this is July 14th?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 THE COMMISSIONER:

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1 Q. Just to make sure I'm--the mark on this, there  
 2 were--before you met with a larger group,  
 3 there were in fact two meetings of Dr.  
 4 Williams, Mr. Gulliver, Dr. Cook, and  
 5 yourself?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 THE COMMISSIONER:  
 9 Q. The first of which we believe occurred on July  
 10 12th?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 THE COMMISSIONER:  
 14 Q. And the second on July 14th?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 THE COMMISSIONER:  
 18 Q. And the larger meeting which included the  
 19 oncologists and surgeons, etc, also occurred  
 20 you believe on the 14th?  
 21 MS. PREDHAM:  
 22 A. Yes, in the evening.  
 23 THE COMMISSIONER:  
 24 Q. Okay, thank you.  
 25 CHAYTOR, Q.C.:

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1 Q. I'll take you back to page one of your notes,  
 2 and they're not dated, so I was trying to  
 3 piece it together as best I could, is this  
 4 your notes from the July 12th meeting?  
 5 MS. PREDHAM:  
 6 A. Yes, because I remember the Jewish General,  
 7 and I remember that was discussed at that  
 8 first one.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay.  
 11 MS. PREDHAM:  
 12 A. And he described--Mr. Gulliver described how  
 13 they purchased it, they sent up staff for  
 14 training, and then it was going then, so I  
 15 remember that.  
 16 CHAYTOR, Q.C.:  
 17 Q. And what have you written here, "We opted for  
 18 Ventana rather than DAKO because", what's this  
 19 word, is it -  
 20 MS. PREDHAM:  
 21 A. Well, it's supposed to be DAKO, but I guess  
 22 that's how I was spelling it at the time,  
 23 DATCO, instead of DAKO.  
 24 CHAYTOR, Q.C.:  
 25 Q. And you didn't finish, okay. What did you

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1 understand then, why was it that they went  
 2 with the Ventana System rather than the DAKO  
 3 at the time?  
 4 MS. PREDHAM:  
 5 A. There was a--I don't think the DAKO was semi-  
 6 automated, they wanted to get that automated  
 7 part of it, and I don't think the DAKO version  
 8 of that was out yet. I think that's the  
 9 rationale why they went with Ventana.  
 10 CHAYTOR, Q.C.:  
 11 Q. Did they have any concern in terms of the  
 12 antigen retrieval under the DAKO, the old DAKO  
 13 system, the antigen retrieval process that was  
 14 used?  
 15 MS. PREDHAM:  
 16 A. The concerns that they had in my memory or my  
 17 knowledge were all limited to the amount of  
 18 manual work that had to go into this, and, you  
 19 know, the descriptions I had was that you had  
 20 to boil the slides--boil the tissue, you know,  
 21 between 15 minutes and 20 minutes, and if you  
 22 did it less than 15, you didn't get the  
 23 release of the antigens, and if you put it  
 24 over 20, then you destroyed the tissue. So it  
 25 was that manual process that they wanted to



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1 eliminate, and when they had seen this one up  
 2 at Jewish General, they liked that system,  
 3 they liked that ability and that's what they  
 4 went for.  
 5 CHAYTOR, Q.C.:  
 6 Q. And it does talk then about things that the  
 7 Ventana system could do, and here, you're  
 8 right, it says the ten times greater  
 9 sensitivity which is consistent with Dr.  
 10 Williams note for the same date, and went back  
 11 and pulled all cases, October, 2001, and can  
 12 you read your own note there?  
 13 MS. PREDHAM:  
 14 A. "Recut and retested".  
 15 CHAYTOR, Q.C.:  
 16 Q. Recut and retested, and I think you stopped in  
 17 mid thought again.  
 18 MS. PREDHAM:  
 19 A. I stopped in mid sentence again.  
 20 CHAYTOR, Q.C.:  
 21 Q. And they followed the manual. "Terry has this  
 22 locked up". What's that referring to?  
 23 MS. PREDHAM:  
 24 A. Referring to the procedures that they would  
 25 have been following for this process, you

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1 know, what the techs had done. So I had asked  
 2 Mr. Gulliver if he had secured that document.  
 3 CHAYTOR, Q.C.:  
 4 Q. And he indicated to you that he had?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And what would be the importance of doing  
 9 that?  
 10 MS. PREDHAM:  
 11 A. Well, just to make sure that we still have it,  
 12 you know, in case it inadvertently got lost or  
 13 whatever.  
 14 THE COMMISSIONER:  
 15 Q. On page two, are we still in the meeting of  
 16 July 12th or are we now into the -  
 17 MS. PREDHAM:  
 18 A. No, July 12th.  
 19 THE COMMISSIONER:  
 20 Q. Okay, thank you.  
 21 CHAYTOR, Q.C.:  
 22 Q. And where did you understand Mr. Gulliver then  
 23 stored the manual?  
 24 MS. PREDHAM:  
 25 A. I assumed it was in his office or Mr. Dyer's

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1 office.  
 2 CHAYTOR, Q.C.:  
 3 Q. Was there anything else that you asked him to  
 4 secure or ask whether or not had been secured?  
 5 MS. PREDHAM:  
 6 A. Well, I guess all documentation would, you  
 7 know would have been a part of my request of  
 8 everything that they had would have to be  
 9 secured, and on the top corner here on the  
 10 left, Thursday morning at 9, that must have  
 11 been the subsequent meeting that we had on the  
 12 14th.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, so then the 14th, okay, yes. At this  
 15 point in time then your first--I take it, this  
 16 is the first real--other than having in your  
 17 possession the May 24th correspondence, this  
 18 is your first initiation into the issue and  
 19 your first opportunity to ask any questions to  
 20 help get this straight in your own mind?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. Because--and you're hearing all this for the  
 25 first time.

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1 MS. PREDHAM:  
 2 A. Yeah.  
 3 CHAYTOR, Q.C.:  
 4 Q. In terms of then Mr. Gulliver informing you  
 5 about the change in the machines going from  
 6 the DAKO to the Ventana, did you ask him do we  
 7 still have the DAKO machine?  
 8 MS. PREDHAM:  
 9 A. At that time, oh, yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. And what did he tell you?  
 12 MS. PREDHAM:  
 13 A. That we no longer had it.  
 14 CHAYTOR, Q.C.:  
 15 Q. And did you ask him where it was, or where it  
 16 went?  
 17 MS. PREDHAM:  
 18 A. He didn't know where it went.  
 19 CHAYTOR, Q.C.:  
 20 Q. He didn't know where it went, and have you  
 21 since learned otherwise?  
 22 MS. PREDHAM:  
 23 A. Well, yes, I understood that I think it was  
 24 last week that it was sold to somebody.  
 25 CHAYTOR, Q.C.:

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1 Q. And throughout the entire investigation of  
 2 this issue by yourself and others, did Mr.  
 3 Gulliver ever tell you otherwise, other than  
 4 in the past couple of weeks?  
 5 MS. PREDHAM:  
 6 A. No, I had no knowledge of where it actually  
 7 went.  
 8 CHAYTOR, Q.C.:  
 9 Q. So other than on the first day when you asked-  
 10 -your first meeting with him you asked where's  
 11 the DAKO machine and he said he didn't know  
 12 where it went, the subject never came up again  
 13 after that?  
 14 MS. PREDHAM:  
 15 A. I think it may have come up, you know, we  
 16 wondered where it was, and I think too that  
 17 they had a flood at the Health Sciences and it  
 18 may have been--you know, he may have thought  
 19 it went somewhere in that, or that kind of  
 20 thing. I got some kind of vague impression  
 21 there, but, you know, it did come up every now  
 22 and then, but not--if we didn't have it, we  
 23 didn't have it.  
 24 CHAYTOR, Q.C.:  
 25 Q. And whenever it did come up, I take it Mr. Joe

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1 White's name never came up?  
 2 MS. PREDHAM:  
 3 A. No.  
 4 CHAYTOR, Q.C.:  
 5 Q. And the fact that he had taken the machine?  
 6 MS. PREDHAM:  
 7 A. No.  
 8 CHAYTOR, Q.C.:  
 9 Q. And the first time you heard that was in the  
 10 last couple of weeks?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And have you had an opportunity to have any  
 15 further discussion with Mr. Gulliver about  
 16 that?  
 17 MS. PREDHAM:  
 18 A. No.  
 19 CHAYTOR, Q.C.:  
 20 Q. I guess he's probably been with us in that  
 21 time period?  
 22 MS. PREDHAM:  
 23 A. Yes, I think he's been.  
 24 CHAYTOR, Q.C.:  
 25 Q. And have you had discussion with anyone else

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1 about that? Were you surprised to learn that,  
 2 that now there's a name of who actually had  
 3 the machine?  
 4 MS. PREDHAM:  
 5 A. Oh yes, I was surprised.  
 6 CHAYTOR, Q.C.:  
 7 Q. You were surprised, okay. And would that have  
 8 been of relevance to you at the time when you  
 9 were conducting, looking into this and trying  
 10 to piece together what was happening, would  
 11 that have been of relevance to you to know  
 12 where the machine had gone and whether or not  
 13 you might still be able to find it?  
 14 MS. PREDHAM:  
 15 A. Well it would have been an answer to a  
 16 question, you know, and then we'd have to  
 17 check into could we find it, what did it mean,  
 18 did we need it, you know, those types of  
 19 things, at least we would have, you know, had  
 20 some direction there, we could go down that  
 21 road and explore it.  
 22 CHAYTOR, Q.C.:  
 23 Q. And I appreciate this is really early days  
 24 here, July 12th and 14th for you in dealing  
 25 with this issue and did you even understand at

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1 this point in time that there would be a  
 2 computer with the machine or a computer used  
 3 to help operate the machine?  
 4 MS. PREDHAM:  
 5 A. No, I can remember my first impression was  
 6 that, you know, it was like a hot plate and a  
 7 pot and, you know, very simplistic, I never  
 8 had an idea that it was actually a machine, I  
 9 don't think at that time, so I probably didn't  
 10 even ask him at that time until later. I  
 11 know, my impression it was very manual and,  
 12 you know, I didn't really think about an  
 13 actual machine. It was more the process and  
 14 the slides and antigens and stuff that we had  
 15 purchased. But that was just, you know, when  
 16 I'm hearing all this information, this is what  
 17 I had visualized.  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, and at some point in time you come to  
 20 appreciate though that there's a computer also  
 21 involved.  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And I take it not too long into the process

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1 you're in that lab and you're talking to  
 2 people and looking around, looking at the  
 3 equipment and trying to learn as much as you  
 4 can about this testing process.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And you said earlier today that about six  
 9 months ago when the request for the Ventana  
 10 computer records came up, at that point it  
 11 dawned on you to, well, was there a computer  
 12 with the DAKO and that's the first time that  
 13 that would have come to your realization. Did  
 14 you ask where's the computer for the DAKO  
 15 machine? What about that, is that still in  
 16 existence or any records from the DAKO  
 17 computer?  
 18 MS. PREDHAM:  
 19 A. Well I would have asked all along for records  
 20 during this period of time.  
 21 CHAYTOR, Q.C.:  
 22 Q. Yes.  
 23 MS. PREDHAM:  
 24 A. And I don't know if I asked a second time at  
 25 that time or not.

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1 CHAYTOR, Q.C.:  
 2 Q. And I take it who would you have been making  
 3 that request of for any records that may have  
 4 existed?  
 5 MS. PREDHAM:  
 6 A. Oh it would have been Mr. Gulliver or Mr.  
 7 Dyer.  
 8 CHAYTOR, Q.C.:  
 9 Q. And what were you told in terms of the  
 10 existence of any relevant records?  
 11 MS. PREDHAM:  
 12 A. We didn't have any.  
 13 THE COMMISSIONER:  
 14 Q. Ms. Chaytor, wherever you can find a spot,  
 15 we'll take the afternoon break.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, well actually this would be a good  
 18 place, please, Commissioner.  
 19 THE COMMISSIONER:  
 20 Q. All right, we'll take a break.  
 21 (RECESS)  
 22 THE COMMISSIONER:  
 23 Q. Please be seated. Ms. Chaytor.  
 24 CHAYTOR, Q.C.:  
 25 Q. Thank you, Commissioner. Registrar, if we

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1 could have, please, P-2152? And page 8,  
 2 please of this document. Ms. Predham, this is  
 3 kind of small, I don't know if we can make it  
 4 a little bit bigger please, Registrar.  
 5 MS. PREDHAM:  
 6 A. I can see that.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay. Ms. Predham, I'll just show you this  
 9 document, it was called an immunohistochemical  
 10 report and it's either May 6th, 1998 or June  
 11 5th, 1998, and there's no patient name noted.  
 12 There is a field for patient name, but it's  
 13 not there, case number with a surgical number  
 14 and we understand this is central, is the CMH.  
 15 The doctor is Khalifa and the technician is  
 16 Peggy. Slide number 19 and 20, antibodies ER  
 17 1 to 50 we understand to be dilution, 30  
 18 minutes; PR 1 to 10, 30 minutes and then a  
 19 protocol set out over here. Ms. Predham, we  
 20 understand from a previous witness that this  
 21 is the type of information that would be on  
 22 the DAKO records for the DAKO machine, for  
 23 running whatever the antibodies were on any  
 24 particular time. And this one was in relation  
 25 to--and this might answer my question, it

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1 looks like it's June 2nd, 1998 and then Peggy  
 2 Welsh, June 5th, 1998. And so this is the  
 3 type of information that might be stored on  
 4 the DAKO computer. If you had been aware of  
 5 the possible existence of this information  
 6 throughout your investigation and of the ER/PR  
 7 issue, might this type of information have  
 8 been of relevance or assistance to you?  
 9 MS. PREDHAM:  
 10 A. Well, it could, I mean, you'd have to check in  
 11 and see what it meant, it would have to be  
 12 explained to me and then you would have to  
 13 look at the dates and see that, but you'd want  
 14 to look and see, you'd want to rule out that  
 15 there was any other factors that were there,  
 16 you know, was it something with, you know, the  
 17 ratio that they using or the timing or, you  
 18 know, was there a pattern of anything. So, it  
 19 was just part of the investigation that  
 20 whatever you have could be totally irrelevant,  
 21 but at least you've reviewed it and you've  
 22 explored the possibility of it.  
 23 CHAYTOR, Q.C.:  
 24 Q. Yes, to look at whether or not, for example,  
 25 on any given date or any particular time

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1 period the same protocols were being used.  
 2 MS. PREDHAM:  
 3 A. Exactly.  
 4 CHAYTOR, Q.C.:  
 5 Q. For example. Also, would it be of some  
 6 assistance in terms of identifying the  
 7 technicians, for example, who ran the test?  
 8 MS. PREDHAM:  
 9 A. I mean, it may be, you know, you don't know  
 10 until--part of when you're looking at an  
 11 investigation into anything like that, you're  
 12 trying to look for patterns and you're trying  
 13 to eliminate things, so until you've got the  
 14 documentation in front of you and you can see,  
 15 especially over this long period of time, you  
 16 really don't know until you start  
 17 investigating what you can look at, any kind  
 18 of pattern that you can come up with.  
 19 CHAYTOR, Q.C.:  
 20 Q. So if you had the document for every test that  
 21 was run on ER/PR during the time period that  
 22 the DAKO was in existence, you could then sit  
 23 down and look through it and see if there's  
 24 any pattern, trend or anything else that might  
 25 be relevant to your investigation?

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. So in that respect, would it have been of use  
 5 to you to know that this type of information  
 6 might exist?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Did anyone bring to your attention that this  
 11 is the type of information that might be in  
 12 the DAKO computer?  
 13 MS. PREDHAM:  
 14 A. No.  
 15 THE COMMISSIONER:  
 16 Q. I would assume that it was just as valuable to  
 17 you if there were no pattern in the sense of -  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 THE COMMISSIONER:  
 21 Q. - part of your job would be eliminating as  
 22 well as looking for -  
 23 MS. PREDHAM:  
 24 A. Exactly. So if, you know, everything run had  
 25 exactly the same percentage and minutes and

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1 all that, well then you can eliminate that as  
 2 a question.  
 3 THE COMMISSIONER:  
 4 Q. Okay, thank you.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, if we can go back, please, I think we  
 7 were looking at P-2940 and we've talked about  
 8 what the comments here mean, and again, this  
 9 is your meeting, your first meeting of July  
 10 12th and can you just read for us, please,  
 11 DAKO's recommendations compared to what we  
 12 did?  
 13 MS. PREDHAM:  
 14 A. Well whatever DAKO was telling us how we had  
 15 to proceed, verses what we actually did. So,  
 16 you know, and I guess that's the understanding  
 17 that we had documentation to say this is what  
 18 we did, so what the manufacturer of the  
 19 equipment was saying we should do and what we  
 20 actually did--if there was any difference.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, so that's what--and these are numbered  
 23 one through six. Is there any particular  
 24 relevance or these are just points that come  
 25 up in the meeting?

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1 MS. PREDHAM:  
 2 A. They were just points at the end, I guess we  
 3 summed up where we were going from.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, so did this mean that somebody was going  
 6 to do a comparison from what DAKO, the  
 7 manufacturer, would have recommended in terms  
 8 of the procedure to be followed, compared to  
 9 what was actually taking place?  
 10 MS. PREDHAM:  
 11 A. Yes. And that's, the note I guess is in  
 12 reference to that is that they followed  
 13 whatever the manual told them to do.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, so there is to be no follow up on that,  
 16 Terry has indicated to you that they followed  
 17 the manual?  
 18 MS. PREDHAM:  
 19 A. Well it would have been, you know, if there  
 20 was documentation that I could have gone back  
 21 to look at, it would have been a comparison to  
 22 what was recommended at the time, compared to  
 23 what was documented, so that, you know, would  
 24 have been an intent to do that.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, and then you would do that in your  
 2 follow up investigation and make those  
 3 inquiries?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And I'll bring you to that in terms of any  
 8 discussions you had with the lab technologists  
 9 regarding that. Number two, dates of -  
 10 MS. PREDHAM:  
 11 A. Dates of those that are different. So what  
 12 were the dates of the ones that converted,  
 13 year to year, rate of positivity by year and  
 14 over there, I've got pattern for rates.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and so you're looking to see if there's  
 17 any, I take it, correlation between the,  
 18 whether or not the same time period or you can  
 19 narrow down the time period.  
 20 MS. PREDHAM:  
 21 A. One of the things that Mr. Gulliver described  
 22 to us in the 40 steps, in the manual process  
 23 of that, is that they would get a--I can't  
 24 remember the technical terms, but it was a  
 25 reagent, say, for lack of a better term,

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1 they'd get a small bottle of reagent from DAKO  
 2 and they would have to pipette microlitres  
 3 out, dilute that in a solution and then that  
 4 would be used for months or a period of months  
 5 in the preparation of the slides. And I guess  
 6 just coming from my perspective, that's one  
 7 step which is an obvious room for error. If  
 8 the reagent was a problem from the  
 9 manufacturer and they had, you know, what was  
 10 the lot number of that, who did the pipetting,  
 11 where was it stored, how long was it in use,  
 12 you know, these were the types of things that  
 13 you would have to go--because if you use that  
 14 for six weeks and you had a pile of  
 15 conversions for six weeks and the rest of the  
 16 year was okay, well then maybe it's something  
 17 to do with that.  
 18 CHAYTOR, Q.C.:  
 19 Q. Yes, or the accuracy of the pipettes for that  
 20 matter that's being used.  
 21 MS. PREDHAM:  
 22 A. Yeah.  
 23 CHAYTOR, Q.C.:  
 24 Q. Thirdly, individual lab -  
 25 MS. PREDHAM:

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1 A. Positivity rate with DAKO testing.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay, and what are you referring to there?  
 4 MS. PREDHAM:  
 5 A. Depending upon diagnosis, rates for  
 6 infiltrating lobular and ductal carcinoma are  
 7 positive.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and this piece, I believe there's a  
 10 similar note in Dr. Williams' notes,  
 11 "Individual lab, positivity rate with DAKO  
 12 testing", is that, do you know what you're  
 13 referring to there?  
 14 MS. PREDHAM:  
 15 A. No, I'm not sure what I meant by individual  
 16 lab.  
 17 CHAYTOR, Q.C.:  
 18 Q. And why do you have "lab" written over to the  
 19 left -  
 20 MS. PREDHAM:  
 21 A. They were going to follow up on that.  
 22 CHAYTOR, Q.C.:  
 23 Q. So these are Dr. Cook and Mr. Gulliver to  
 24 follow up?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. Test all samples for living patients, that's  
 4 self explanatory; need a -  
 5 MS. PREDHAM:  
 6 A. A meeting to inform oncologists and Cancer  
 7 Clinic Program.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and so up to this point in time, they  
 10 hadn't been informed?  
 11 MS. PREDHAM:  
 12 A. Well I guess the ones that were involved in  
 13 this up to that point in time, but not as a  
 14 group.  
 15 CHAYTOR, Q.C.:  
 16 Q. Not as a group, okay. And what does this say?  
 17 MS. PREDHAM:  
 18 A. Check with Dr. Ejeckam regarding a memo--or  
 19 dash memo.  
 20 CHAYTOR, Q.C.:  
 21 Q. And who was to do that?  
 22 MS. PREDHAM:  
 23 A. Dr. Cook.  
 24 CHAYTOR, Q.C.:  
 25 Q. Meaning the memo at this point in time, the

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1 only one that you were referred to was the  
 2 July 19th or June 19th -  
 3 MS. PREDHAM:  
 4 A. I hadn't seen it yet, but there was a  
 5 reference that there was a memo, that he had  
 6 sent to all pathologists I think was the--and  
 7 it was probably the earlier one, actually.  
 8 CHAYTOR, Q.C.:  
 9 Q. And then when you got the June 19th one,  
 10 though, that was sent to Terry Gulliver, it  
 11 didn't occur to you at the time, well I  
 12 thought the memo went to all pathologists?  
 13 MS. PREDHAM:  
 14 A. No.  
 15 CHAYTOR, Q.C.:  
 16 Q. So coming out of then the first meeting, what  
 17 was it that you were to do?  
 18 MS. PREDHAM:  
 19 A. After that first meeting, I didn't have  
 20 anything that I actually had to do before  
 21 Thursday at 9:00.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, so the next time you get together then  
 24 is Thursday, July 14th?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And you're not to necessarily do anything in  
 4 the meantime?  
 5 MS. PREDHAM:  
 6 A. Well I told our department about it and -  
 7 CHAYTOR, Q.C.:  
 8 Q. You told your department?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And you leave this meeting and you call the  
 13 insurer and inform the insurer?  
 14 MS. PREDHAM:  
 15 A. I'm not sure if I told them at this one or  
 16 after the next one, it was one or the other.  
 17 THE COMMISSIONER:  
 18 Q. Where it says "test all samples for living  
 19 patients"--No. 4, that is "patients" isn't it?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 THE COMMISSIONER:  
 23 Q. What did you understand that meant?  
 24 MS. PREDHAM:  
 25 A. Right there it sounds like we're going to test

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1 everyone, but I think, I think it was always  
 2 only negative, but it does look there that we  
 3 were thinking all of them.  
 4 THE COMMISSIONER:  
 5 Q. And all meant all? What did all mean?  
 6 MS. PREDHAM:  
 7 A. Well my memory is that we always considered  
 8 just negative patients, negative ER, negative  
 9 patients.  
 10 THE COMMISSIONER:  
 11 Q. Yes, but what I'm thinking of is what year  
 12 range at that--were you thinking of testing  
 13 all patients for a particular year or a  
 14 particular time frame or, you know, what was  
 15 the--who was going to be lumped into "all" at  
 16 that point?  
 17 MS. PREDHAM:  
 18 A. Sorry, all the patients tested on DAKO from  
 19 '97 to 2004.  
 20 THE COMMISSIONER:  
 21 Q. So that decision was made at that point.  
 22 MS. PREDHAM:  
 23 A. Yes. I think it was made before that with Dr.  
 24 Cook and Dr. Williams.  
 25 THE COMMISSIONER:

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1 Q. Okay.  
 2 CHAYTOR, Q.C.:  
 3 Q. And then if we continue on then to the next  
 4 page, is this then the meeting of you and Drs.  
 5 Cook and Williams and Mr. Gulliver on July  
 6 14th?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. And so this is a meeting that occurs prior to  
 11 the larger group meeting which we know  
 12 occurred July 14th.  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And if we look ahead in your notes, for  
 17 example, we see then up at page 6, meeting and  
 18 a list of individuals.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And would this be the same date, July 14th and  
 23 the larger group meeting?  
 24 MS. PREDHAM:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. Okay. And so then between page 3, page 4,

3 page 5, are these all notes from the same

4 meeting of the smaller group on July 14th? Do

5 you want to just have a look down through?

6 MS. PREDHAM:

7 A. Can I just scroll down through?

8 CHAYTOR, Q.C.:

9 Q. Sure, absolutely. This notebook, maybe that's

10 a question I should ask you, this notebook,

11 was this just used for ER/PR?

12 MS. PREDHAM:

13 A. No.

14 CHAYTOR, Q.C.:

15 Q. This was used for other things and you've gone

16 through and identified the relevant portions,

17 I take it.

18 MS. PREDHAM:

19 A. Yes.

20 CHAYTOR, Q.C.:

21 Q. The ER/PR issue.

22 MS. PREDHAM:

23 A. And as you can tell, I was not very good at

24 writing dates down, so I went through and

25 figured out the dates. Yes, that was up to

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1 that point, up to here, that was from that

2 same meeting.

3 CHAYTOR, Q.C.:

4 Q. Okay. And then we go into the next page, top

5 of page 6 and then there's a meeting of the

6 larger group and I take it the line is drawn

7 so the next meeting starts after the line and

8 where you've written the people in attendance?

9 MS. PREDHAM:

10 A. Yes.

11 CHAYTOR, Q.C.:

12 Q. Okay. So I'll take you then through those

13 notes back to page 3 of the exhibit, June

14 19th, 2003 memo, Dr. Ejeckam spoke with Terry

15 and Barry. So this is what's being--you've

16 now been presented, I take it, with the June

17 19th memo.

18 MS. PREDHAM:

19 A. And Mr. Gulliver is telling us what happened

20 around that.

21 CHAYTOR, Q.C.:

22 Q. Okay, and the senior tech left in April. What

23 was that in reference to?

24 MS. PREDHAM:

25 A. One of the techs in that area had left in

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1 April and these were, the issues were after

2 she left, I think.

3 CHAYTOR, Q.C.:

4 Q. I'm sorry, the issues -

5 MS. PREDHAM:

6 A. In Dr. Ejeckam's memo were belated until after

7 she left.

8 CHAYTOR, Q.C.:

9 Q. Okay, and was that somehow being suggested to

10 be relevant to what Dr. Ejeckam was concerned

11 about?

12 MS. PREDHAM:

13 A. Well I think he referenced in his memo about

14 workflow and other duties and succession

15 planning, you know, with the people who were

16 leaving. And I guess that was just a factor

17 that there was a senior tech there who left in

18 April and then there was some turnover of

19 staff and that.

20 CHAYTOR, Q.C.:

21 Q. Okay. "Isn't enough work to have three people

22 dedicated to immunostains". Who was

23 expressing that?

24 MS. PREDHAM:

25 A. Mr. Gulliver.

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1 CHAYTOR, Q.C.:

2 Q. And what did you understand to be the status

3 as of--this is July 14th, 2005, were the

4 t e c h n o l o g i s t s d e d i c a t e d t o

5 immunohistochemistry?

6 MS. PREDHAM:

7 A. I think I noted it just down a little bit

8 farther where it says "after the memo, they

9 were limited to grossing and staining", so

10 they would do some grossing work, they would

11 rotate through there and then do the

12 immunostains.

13 CHAYTOR, Q.C.:

14 Q. Okay. And No. 3, is there any significance to

15 this No. 3?

16 MS. PREDHAM:

17 A. I think it was the third point on Dr.

18 Ejeckam's memo that I was referring to.

19 Before, this was before he wrote the memo or

20 to that point, they were doing routine work as

21 well and the volumes had been going up in

22 immunostains.

23 CHAYTOR, Q.C.:

24 Q. And after memo, then they were committed to

25 grossing and staining.

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. So that's what you understood took place to  
 5 address Dr. Ejeckam's concern -  
 6 MS. PREDHAM:  
 7 A. In response to -  
 8 CHAYTOR, Q.C.:  
 9 Q. - regarding the staff rotations.  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. Or the staff not being dedicated. "And senior  
 14 tech then again left in April. Senior tech  
 15 came over from St. Clare's for six weeks to be  
 16 orientated."  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. And who told you that the senior tech came  
 21 over for six weeks of orientation?  
 22 MS. PREDHAM:  
 23 A. I would assume that would be Mr. Gulliver.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, and in your questioning on this issue,

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1 did you learn any or speaking to the  
 2 technologists themselves, did you learn any  
 3 different than that as to the length of time  
 4 by which any of them had been orientated?  
 5 MS. PREDHAM:  
 6 A. I don't think so.  
 7 CHAYTOR, Q.C.:  
 8 Q. And would you have spoken with Mr. Simms, Les  
 9 Simms?  
 10 MS. PREDHAM:  
 11 A. Oh yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. And did that question come up with him, did  
 14 you ask him how long he had been orientated or  
 15 is that an issue that never came up?  
 16 MS. PREDHAM:  
 17 A. I can't remember, I don't remember anything  
 18 about orientation.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and "proficiency testing in pathology,  
 21 can we be one hundred percent sure that the  
 22 Ventana work?" And then "No." What's this  
 23 about?  
 24 MS. PREDHAM:  
 25 A. Well I guess that was a question that was

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1 raised in our discussion about the Ventana  
 2 and, you know, how are we--how do we know that  
 3 it works, like how can we be sure that it  
 4 works. And I guess that led to getting the  
 5 Ventana representative down to verify that we  
 6 had it set up and it was running well.  
 7 CHAYTOR, Q.C.:  
 8 Q. And who would have said that you couldn't be a  
 9 hundred percent sure? Who would have  
 10 responded no to that question?  
 11 MS. PREDHAM:  
 12 A. I'm not sure, like I said again, that must  
 13 have been the consensus around the table.  
 14 CHAYTOR, Q.C.:  
 15 Q. And "PD", I take it it's Peggy Deane?  
 16 MS. PREDHAM:  
 17 A. Oh it could be, yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. So you know her identify at this point?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. "Infiltrating lobular carcinoma, very unusual  
 24 to be negative." And reference to  
 25 oncologists.

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And who in your meeting with Mr. Gulliver and  
 5 Mr. Cook would be relaying this information?  
 6 MS. PREDHAM:  
 7 A. It would have been either, I would say Dr.  
 8 Cook or Dr. Williams.  
 9 CHAYTOR, Q.C.:  
 10 Q. And I take it up to this point in time, you  
 11 haven't had any discussions with the  
 12 oncologist, anything you're learning about  
 13 Peggy Deane's case is being relayed through  
 14 Mr. Gulliver or Dr. Cook or Dr. Williams?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. And then there's reference to some percentages  
 19 here, "50 to 80 percent should be positive.  
 20 2002"--is that 50 percent positive?  
 21 MS. PREDHAM:  
 22 A. That's 50 percent positive.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay. And who is providing these statistics  
 25 and what's being referred to?



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1 MS. PREDHAM:  
 2 A. Again, it would have to be Dr. Cook or Mr.  
 3 Gulliver and the 50 to 80 percent should be  
 4 positive, I guess was the, you know,  
 5 established what they understood to be the  
 6 literature saying what the positivity rate  
 7 should be and from their review at that time,  
 8 they found that in 2002, there was a 50  
 9 percent positive rate based on our St. John's  
 10 results, because that's all they would have  
 11 been able to -  
 12 CHAYTOR, Q.C.:  
 13 Q. And that's ER positivity, I take it?  
 14 MS. PREDHAM:  
 15 A. Yes. Now I say that now, that it is that,  
 16 because we looked at--as it went along when we  
 17 were trying to determine how to identify  
 18 patients, the discussion was about just  
 19 limiting to the ER because we couldn't always  
 20 be sure that the PR was treatable, and along  
 21 the way it's, you know, were we always  
 22 focusing on the ER or were we looking at the  
 23 combination of ER/PR, it's a big vague now in  
 24 those early days.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And Sunnybrook is 75 percent positive,  
 2 so somebody in attendance is able to say  
 3 they've checked with Sunnybrook for their  
 4 positivity rates?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And May, 1997, got the DAKO system?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And this 16 out of 25 positive in second  
 13 group?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. So I take it that's the results of the testing  
 18 that had taken place in house, in 16 out of 25  
 19 had converted to positive?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And then again you have a list, so this is  
 24 what, I take it the consensus or decisions  
 25 coming out of the meeting?

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. "Identify the affected people, assign  
 5 resources to Bev." I take it that's Bev  
 6 Carter?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. And what did you understand Dr. Carter was  
 11 going to do?  
 12 MS. PREDHAM:  
 13 A. That she was going to co-ordinate this  
 14 process, you know, she was going to determine  
 15 who the affected people were and co-ordinate  
 16 the retesting.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, and would she also do any type of an  
 19 investigation in terms of looking at the  
 20 original slides or trying to piece together  
 21 for those cases that converted how that could  
 22 be?  
 23 MS. PREDHAM:  
 24 A. Well certainly she would do that and I don't  
 25 know--I don't know if I would have understood

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1 the nuances between the slides and the blocks  
 2 at that time and relooking at the slides and  
 3 what that would have meant. It could have  
 4 been that I knew that at that time or not.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, but you did understand that in addition  
 7 to co-ordinating the retesting process, she'd  
 8 be doing some investigative work to try and  
 9 ascertain what the contributing cause or  
 10 causes might be?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And here you do note testing of all negative  
 15 and then testing of all live patients. So I  
 16 take it you meant it was going to be all  
 17 negatives and whether it was narrowed down to  
 18 ERs, you're not sure at this point.  
 19 MS. PREDHAM:  
 20 A. No.  
 21 CHAYTOR, Q.C.:  
 22 Q. But it would be the negative live patients.  
 23 MS. PREDHAM:  
 24 A. Yes, and I guess, you know, at this point it  
 25 was the concept of negative because that was

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1 the people who were affected, you know,  
 2 because of treatment. And it wasn't until we  
 3 started saying, okay, exactly how are we going  
 4 to identify them? What is negative? Then  
 5 that's when we narrowed it down to only we'd  
 6 focus on ER to generate the list to identify  
 7 patients.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and then meet with the surgeons and  
 10 oncologists. And thirdly, "tell the public  
 11 two to three hundred people." And is this  
 12 consensus coming from you and Mr. Gulliver and  
 13 Dr. Cook and Dr. Williams?  
 14 MS. PREDHAM:  
 15 A. Well it would have been--well it wouldn't be  
 16 consensus for me because I wouldn't be able to  
 17 put any information into it, that would have  
 18 to be from Dr. Cook and Mr. Gulliver.  
 19 CHAYTOR, Q.C.:  
 20 Q. And Dr. Williams is in attendance too.  
 21 MS. PREDHAM:  
 22 A. Yes, well I guess he would have, he wouldn't  
 23 have known first hand how many people it would  
 24 have affected.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay, in terms of the numbers of people.  
 2 MS. PREDHAM:  
 3 A. Right.  
 4 CHAYTOR, Q.C.:  
 5 Q. Yes, okay, yes, I see what you're saying. So  
 6 the numbers of two to three hundred people,  
 7 that's coming from Mr. Gulliver and Dr. Cook.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. And the decision to tell however the public,  
 12 what's being referred to here, you're going to  
 13 tell the public what? What exactly would the  
 14 public be told?  
 15 MS. PREDHAM:  
 16 A. I guess at that stage that we have an issue  
 17 and that we're going to have to go back and  
 18 retest people.  
 19 CHAYTOR, Q.C.:  
 20 Q. And that there might be two to three hundred  
 21 people being rested or is that what this is?  
 22 MS. PREDHAM:  
 23 A. Mostly likely that's why--that it would affect  
 24 two to three hundred people or it would be two  
 25 to three hundred people retested, I'm not

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1 really sure now.  
 2 CHAYTOR, Q.C.:  
 3 Q. And in terms of the decision to tell the  
 4 public, that's what's coming out of the  
 5 meeting here with Drs. Williams, Cook,  
 6 yourself and Mr. Gulliver?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay. And did you have any difficulty with  
 11 that?  
 12 MS. PREDHAM:  
 13 A. No.  
 14 CHAYTOR, Q.C.:  
 15 Q. "Assess current testing, cross-referencing  
 16 with another lab."  
 17 MS. PREDHAM:  
 18 A. And that was, I guess, to verify that question  
 19 as well with the Ventana is to just make sure  
 20 that, you know, our results, our current  
 21 results were good.  
 22 CHAYTOR, Q.C.:  
 23 Q. "And assess our standards and quality of  
 24 service. External consultant to be brought  
 25 in." So this again is July 14th and the

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1 decision to bring an external consultant in  
 2 and the purpose of that at this point in time,  
 3 what was envisioned would be the mandate for  
 4 an external consultant?  
 5 MS. PREDHAM:  
 6 A. Well that would be to review our current  
 7 practice, so you know, do we have the system  
 8 set up correctly, are we following the  
 9 protocols, are we, you know, that kind of  
 10 thing.  
 11 CHAYTOR, Q.C.:  
 12 Q. And would that be then, is that referenced to  
 13 the Ventana consultant or -  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. This is who this is, okay. At this point in  
 18 time Trish Wegrynowski hasn't been thought of  
 19 or -  
 20 MS. PREDHAM:  
 21 A. No.  
 22 CHAYTOR, Q.C.:  
 23 Q. And in the discussion to tell the public, was  
 24 there any discussion as well about what to  
 25 tell the patients?

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1 MS. PREDHAM:  
 2 A. At that point, I don't think we got into a lot  
 3 of detail at that, at that point. I mean,  
 4 certainly that's something we would have to  
 5 discuss and determine.  
 6 CHAYTOR, Q.C.:  
 7 Q. And then that's it for that page. The top of  
 8 the next page, page six of the exhibit, it's  
 9 written here "Radio Noon interview tomorrow"  
 10 and asterisk "news release." Do you recall  
 11 what that is referencing?  
 12 MS. PREDHAM:  
 13 A. I have a vague memory that it was an option  
 14 that somebody could be interviewed on Radio  
 15 Noon as early as tomorrow. Like I can  
 16 remember that statement being made, and it's  
 17 just there out of the blue. It doesn't look  
 18 like it's related to the previous one because  
 19 nobody around that table would have been  
 20 thinking that, and I don't know if I had  
 21 talked to Ms. Bonnell before that and that  
 22 happened to be a discussion or not. It just--  
 23 it's a random note there.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, yes, because if we look down through

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1 your--it's not written onto your page of notes  
 2 -  
 3 MS. PREDHAM:  
 4 A. No.  
 5 CHAYTOR, Q.C.:  
 6 Q. - from that meeting, but it's at the top of  
 7 the page before you go into the larger meeting  
 8 that same day?  
 9 MS. PREDHAM:  
 10 A. Yes. So it's almost like something, a  
 11 conversation that I must have had in between  
 12 the two meetings, and there seems to be some  
 13 vague memory of "well, we could go on Radio  
 14 Noon tomorrow," you know, or -  
 15 CHAYTOR, Q.C.:  
 16 Q. For an interview tomorrow?  
 17 MS. PREDHAM:  
 18 A. Yeah.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and the idea of a news release, perhaps  
 21 that was discussed as well with Ms. Bonnell?  
 22 MS. PREDHAM:  
 23 A. Right.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, and the patients that out of the 16

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1 patients, 16 out of 25 your handwritten note  
 2 referred to here, were you told any  
 3 information as to how many of them had already  
 4 been informed of their changes in their  
 5 results?  
 6 MS. PREDHAM:  
 7 A. I think I understood that they were all  
 8 informed at that time. I think, and you know,  
 9 it's hard to know what you know at a certain  
 10 point in time, where it was so quick, it  
 11 quickly evolved.  
 12 CHAYTOR, Q.C.:  
 13 Q. So it was your understanding that all of them  
 14 knew or some significant portion, ten out of  
 15 16 does that ring any bells?  
 16 MS. PREDHAM:  
 17 A. Well, you know, my memory is that they were in  
 18 the process of being informed or informed and  
 19 I didn't have any concerns that there were  
 20 people who had to be informed. Like I had no  
 21 concern, that concern that there were people  
 22 whose test results had converted and they  
 23 hadn't been informed.  
 24 CHAYTOR, Q.C.:  
 25 Q. And were you told what they had been told?

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1 MS. PREDHAM:  
 2 A. Well, that the results have changed, you know.  
 3 That's all I remember.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and in terms of what Dr. Carter was  
 6 going to be doing, did you see anything in  
 7 writing outlining what the plan basically was,  
 8 her plan of action, or summarizing what it was  
 9 planned for her to do?  
 10 MS. PREDHAM:  
 11 A. I don't think so at that time. I think I've  
 12 seen something since then, but I don't think I  
 13 saw it at that time.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and then we'll continue on then with the  
 16 meeting of the larger group and you've written  
 17 here, Dr. Gardiner, Kwan--Drs. Gardiner, Kwan,  
 18 Felix, Laing, McCarthy, Ms. Bonnell, Ms.  
 19 Deborah Thomas, Dr. Williams and yourself.  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And were there others in attendance besides or  
 24 is this everyone that you recall being there?  
 25 MS. PREDHAM:

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1 A. That's it. I mean, if there was somebody  
 2 else, I would have wrote it in, I would think.  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay, and what did you understand the purpose  
 5 for this meeting?  
 6 MS. PREDHAM:  
 7 A. Although Dr. Cook is not there. Usually he  
 8 would be there, you know. This is a--we had  
 9 discussed earlier that we had to inform the  
 10 oncologists and the surgeons and this was the  
 11 meeting to do that.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay, and so in terms of--and if we could look  
 14 then, please, at 0925, and I'll just come back  
 15 to this, but 0925, please, and page three of  
 16 this document then? We have--this is Dr.  
 17 Williams' notes, so he indicates--this is his  
 18 list of who was in attendance, and it does  
 19 have -  
 20 MS. PREDHAM:  
 21 A. Dr. Cook.  
 22 CHAYTOR, Q.C.:  
 23 Q. - Dr. Cook in attendance, and everyone else is  
 24 the same as yours.  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay, and if we could go back then, please, to  
 4 2940? And so in terms of informing the  
 5 oncologists as to what's happening, and the  
 6 surgeons, who would have been taking the lead  
 7 at this meeting?  
 8 MS. PREDHAM:  
 9 A. Well--oh, who would have been conducting -  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes.  
 12 MS. PREDHAM:  
 13 A. Dr. Williams would have been taking the lead  
 14 in that meeting.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and it's "1997 to March 2004, they just  
 17 retested their lobular cancer and got 100  
 18 percent confirmed that it would be" is that  
 19 "published in pathology journal"?  
 20 MS. PREDHAM:  
 21 A. Yes, I think that's the information from  
 22 Sloan-Kettering.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay, and who in the meeting--is this what you  
 25 were saying that you thought either Dr.

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1 McCarthy or Dr. Laing was relaying?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and so you understood that Sloan-  
 6 Kettering had retested their lobular cancers  
 7 and 100 percent of them were positive?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. And these are notes you're making in the  
 12 meeting?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And you understood that whatever had come from  
 17 that exercise, it was going to be published in  
 18 a pathology journal?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And then you have "40-50 positive, negative,  
 23 but were now strongly positive." Do you  
 24 recall what that's referencing?  
 25 MS. PREDHAM:

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1 A. I think that was--no, I don't know if it was  
 2 the second batch now or if it was something  
 3 that they had. Like I'm not sure.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and the next sentence looks like "Ford  
 6 said there was a problem with the system, but  
 7 it was fixed."  
 8 MS. PREDHAM:  
 9 A. I do recall that sentence being made. That  
 10 was Dr. McCarthy, I believe, said that she  
 11 knew there was a problem back in the day, only  
 12 because she was in a meeting in with Dr. Elms  
 13 had said that there was a problem with the  
 14 system but now it's fixed, and she mentioned  
 15 that she knew that there was a problem earlier  
 16 on.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay, and Dr. Cook is in attendance at this  
 19 meeting when Dr. McCarthy would have stated  
 20 that, and did Dr. Cook--I know he's not on  
 21 your list, but he's in Dr. Williams' list.  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. Did Dr. Cook raise any concern with that

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1 statement or challenge it in any way?  
 2 MS. PREDHAM:  
 3 A. I don't recall. She just kind of made it as  
 4 a, you know, this is what she had heard  
 5 earlier.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, and if Dr. Cook had said something to  
 8 the contrary, would we expect that you would  
 9 have made a note of that as well?  
 10 MS. PREDHAM:  
 11 A. Yes, if there was any response, my memory is  
 12 that there was just some--yes, Dr. Ejeckam  
 13 stopped testing and, you know, whatever, and  
 14 he made some comment on that in that general  
 15 line. I don't have any--you know, he never  
 16 said "hold on, there was no problem" or  
 17 anything. It was just that type of thing.  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, and this is reference to the meeting on  
 20 May 17th, Joy McCarthy, Kara Laing, was there  
 21 any other discussion about that meeting?  
 22 MS. PREDHAM:  
 23 A. I guess the other discussion was like the next  
 24 point, the fact that they took 25 patients,  
 25 mostly from 2002, breast cancer, who were

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1 negative, I assume. 16 out of 25, in the  
 2 process of going through 33 more.  
 3 CHAYTOR, Q.C.:  
 4 Q. And is this sampling 2002?  
 5 MS. PREDHAM:  
 6 A. Yeah.  
 7 CHAYTOR, Q.C.:  
 8 Q. And what -  
 9 MS. PREDHAM:  
 10 A. And I guess 2001 and 2000, I guess, you know,  
 11 probably somebody said we were sampling 2002  
 12 and somebody else may have said well, we've  
 13 got some 2001 and 2000 here.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and then you have an asterisk, and it  
 16 looks like "about at least 12."  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. And what are you referring to there?  
 21 MS. PREDHAM:  
 22 A. I have no idea.  
 23 CHAYTOR, Q.C.:  
 24 Q. And is that--and then there's reference -  
 25 MS. PREDHAM:

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1 A. You know, there was a lot of discussion about  
 2 Tamoxifen and who were candidates, and you  
 3 know, there was pre-menopausal, post-  
 4 menopausal, because over time, the criteria  
 5 for being a candidate of Tamoxifen changed.  
 6 So I think they were into this discussion and  
 7 I just couldn't keep up with what they were  
 8 saying, so I was just writing down.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay.  
 11 MS. PREDHAM:  
 12 A. But I have no idea what "about at least 12" -  
 13 CHAYTOR, Q.C.:  
 14 Q. And whether or not that's 12 out of the 16,  
 15 for example? One possibility it might be that  
 16 12 out of 16 informed or don't know, not sure?  
 17 MS. PREDHAM:  
 18 A. I have no idea.  
 19 CHAYTOR, Q.C.:  
 20 Q. "Treatment would have been very different"  
 21 then you got three asterisks. "Controls are  
 22 supposed to be done every day and documented.  
 23 Were they done?"  
 24 MS. PREDHAM:  
 25 A. Well, that's a note to me to -

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1 CHAYTOR, Q.C.:  
 2 Q. Follow up on that?  
 3 MS. PREDHAM:  
 4 A. Yeah.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, so this is why you made this with three  
 7 asterisks, that you're going to go away and  
 8 find out?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. "Controls on a separate slide versus the"--  
 13 what is this?  
 14 MS. PREDHAM:  
 15 A. Test, I guess.  
 16 CHAYTOR, Q.C.:  
 17 Q. Versus the test.  
 18 MS. PREDHAM:  
 19 A. TE.  
 20 CHAYTOR, Q.C.:  
 21 Q. Okay, versus the test, the sample, I guess,  
 22 the specimen. Okay, and "who is responsible  
 23 for the patient? Oncologist, surgeon." So  
 24 was there a discussion about that in the room?  
 25 MS. PREDHAM:

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1 A. Well, that was part of the disclosure. So  
 2 when the results come back, who did they go  
 3 back to? Who was responsible for the patient  
 4 to have that discussion with them?  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, and then you lose your thought here, "if  
 7 they still have -  
 8 MS. PREDHAM:  
 9 A. And I think that that was part of the  
 10 discussion was there had been so much turnover  
 11 of oncologists, it was possible that they may  
 12 not still have an oncologist that -  
 13 CHAYTOR, Q.C.:  
 14 Q. Oh, if they still have such physician, okay.  
 15 MS. PREDHAM:  
 16 A. Yeah.  
 17 CHAYTOR, Q.C.:  
 18 Q. And then going into the next page, is this  
 19 still the same meeting?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. There's a plan, okay, and the plan is a  
 24 hotline and -  
 25 MS. PREDHAM:

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1 A. We need results.  
 2 CHAYTOR, Q.C.:  
 3 Q. - results, I'm sorry, so what does that refer  
 4 to?  
 5 MS. PREDHAM:  
 6 A. Well, we'd need to have, you know, some place  
 7 for people to call. If we were going to go  
 8 public, we'd need to have some place for  
 9 people to call and also we needed a plan with  
 10 the results, how, once we got the results, how  
 11 were they going to get communicated.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay, and the discussion to have--to go public  
 14 and to use a hotline for people to be able to  
 15 call to, was there any discussion in the room  
 16 in terms of any concern expressed to doing  
 17 that, to going public? Was there any concern  
 18 expressed?  
 19 MS. PREDHAM:  
 20 A. No, not then, you know, that we would have to--  
 21 we'd have to get the hotline in place for  
 22 people to call and respond when they hear it,  
 23 because you know, it would be a big  
 24 announcement, you know, that would--and they'd  
 25 need to call somebody for more information.

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1 CHAYTOR, Q.C.:  
 2 Q. And the oncologists and surgeons are present  
 3 at this meeting, and the purpose being to  
 4 inform them, and did they express any concern  
 5 that their preference would be to have a  
 6 hotline, for example, set up somewhere where  
 7 the patients could be calling, as opposed to  
 8 inundating their offices, for example, with  
 9 calls?  
 10 MS. PREDHAM:  
 11 A. And possibly that's where the idea of having  
 12 that central line to come in, because I guess,  
 13 you know, if you see people who have cancer  
 14 and you're coming out saying that we have  
 15 cancer test results that are inaccurate,  
 16 you're going to be inundated with calls. So  
 17 maybe that's where that came from, but it  
 18 makes sense, but I really don't remember that.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and "guideline to how we deal with the  
 21 treatment, Kara Laing and Joy McCarthy." Do  
 22 you recall what that was about?  
 23 MS. PREDHAM:  
 24 A. There was some kind of discussion, and I guess  
 25 it came from the previous thought that if they

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1 didn't have an oncologist right now, how would  
 2 a GP know what to do with the new results or  
 3 whatever. So there had to be some kind of  
 4 guideline on how to deal with those treatment  
 5 decisions.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay.  
 8 MS. PREDHAM:  
 9 A. And they were going to go away and think about  
 10 that.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay, and "farm it out" you've written here.  
 13 MS. PREDHAM:  
 14 A. That's for the retesting to--because they were  
 15 concerned about the delay too, the time lines  
 16 and I don't think it was this meeting, I think  
 17 it was probably the next one, they were very  
 18 concerned about how accurate our time lines  
 19 were and how if we went out too soon, there'd  
 20 be too long of a period of time. They wanted  
 21 to be very sure on what we were doing and how  
 22 long--how quickly we were going to get the  
 23 results back so people would understand. I  
 24 don't think that was really discussed at that  
 25 point. I think they had to go away and think

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1 about that and the implications of that.  
 2 CHAYTOR, Q.C.:  
 3 Q. And that comes up later?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay, so farming it out, at this point is  
 8 referring to the retesting though or was it  
 9 in--at this point in time, was the plan to  
 10 have the retesting done in house?  
 11 MS. PREDHAM:  
 12 A. I think it was done in house, if we could do  
 13 it. I think that may be the question was  
 14 there, is if we could handle the volume.  
 15 CHAYTOR, Q.C.:  
 16 Q. And you're also contemplating having the  
 17 Ventana person come in to check out your  
 18 current system?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And you have three asterisks again, so "June  
 23 13th" is that correct, "send them in and get  
 24 them retested."  
 25 MS. PREDHAM:

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1 A. I believe that's when Dr. Cook notified the  
 2 other pathologists to send in their blocks and  
 3 slides.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and then resources, and it looks like  
 6 "social work and nursing," is that correct?  
 7 MS. PREDHAM:  
 8 A. And that was we were talking about what  
 9 resources we could tap into for the hotline.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay.  
 12 MS. PREDHAM:  
 13 A. And so PPCs for social work and nursing would  
 14 be good.  
 15 CHAYTOR, Q.C.:  
 16 Q. I'm sorry, what's PPC?  
 17 MS. PREDHAM:  
 18 A. Oh, professional practice coordinator, sorry.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and was there any consideration to  
 21 consulting social work, social workers in  
 22 terms of patient communication or how patient  
 23 communication should be handled?  
 24 MS. PREDHAM:  
 25 A. No. The note there was more of utilizing them

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1 when the hotline got set up.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay, to use them to answer the phones?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And why would social work and nursing be  
 8 appropriate people to be answering the calls?  
 9 MS. PREDHAM:  
 10 A. Well, I guess our thinking was that you'd like  
 11 to have someone with a clinical background and  
 12 someone who was used to talking patients about  
 13 issues, and that would seem like an option.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and then it's "Cancer Registry, 1997  
 16 list of live patients."  
 17 MS. PREDHAM:  
 18 A. Well, it came up, you know, our plan had been  
 19 to retest the live patients first, and it was  
 20 trying to determine who were the live  
 21 patients. So Dr. McCarthy suggested that she  
 22 could get me in touch with the IT people at  
 23 the Cancer Clinic and get access to the Cancer  
 24 Registry for breast cancer patients, because  
 25 that would tell us who was alive and who was

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1 deceased.  
 2 CHAYTOR, Q.C.:  
 3 Q. And then the final page, that appears to be -  
 4 MS. PREDHAM:  
 5 A. And this was just notes from--Dr. McCarthy  
 6 was--the name that's blacked out there was the  
 7 IT person.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay.  
 10 MS. PREDHAM:  
 11 A. And this was information that we could get -  
 12 CHAYTOR, Q.C.:  
 13 Q. We weren't sure. We were erring on the side  
 14 of caution.  
 15 MS. PREDHAM:  
 16 A. The information there was the information that  
 17 was available from the Cancer Registry. So it  
 18 would have the names of the patients, the MCP  
 19 number, the surgical--the specimen number is  
 20 actually what it is, and their status, whether  
 21 they were alive or deceased.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and the IT person, was that person to be  
 24 consulted in terms of what?  
 25 MS. PREDHAM:

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1 A. Oh, he was to get the information out of the  
 2 Registry for me.  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay, for the list of names?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay, and did that prove to be a good source  
 9 for you?  
 10 MS. PREDHAM:  
 11 A. It was a period of time before I got it, and  
 12 the information was incomplete. I thought I  
 13 had--I think I had a different perception of  
 14 what actually the Cancer Registry was, you  
 15 know, and I was a bit surprised that it wasn't  
 16 as complete as I thought it would be. I  
 17 thought it was something that was linked with  
 18 Vital Stats or whatever, but it wasn't. That  
 19 was not how they did, I think the term is  
 20 death clearance, in the Registry.  
 21 CHAYTOR, Q.C.:  
 22 Q. And when did you learn that difference, Ms.  
 23 Predham? When did you learn that they weren't  
 24 actually linked to Vital Statistics?  
 25 MS. PREDHAM:

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1 A. I guess it was, you know, when I started  
 2 looking at there was a lot of gaps in the  
 3 information, and I guess at that point in  
 4 time, you know, it was just, I guess,  
 5 registering, slowly coming into me that they  
 6 weren't registered. I'm not really sure when  
 7 I learned that they weren't--they were a  
 8 stand-alone type of -  
 9 CHAYTOR, Q.C.:  
 10 Q. Is it after you start into the process of  
 11 results coming back and patients having to be  
 12 notified? Is it that late in the process?  
 13 MS. PREDHAM:  
 14 A. It may have been. I know it was when I got it  
 15 and trying to determine who was deceased and  
 16 who wasn't. There were a lot of gaps in the  
 17 information. There were problems with the MCP  
 18 numbers, that type of thing. So I started,  
 19 you know, questioning how do you get your  
 20 information or where does this come from.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, and what were you expecting? How was it  
 23 less than what you were expecting?  
 24 MS. PREDHAM:  
 25 A. Oh, I just thought there would be some process

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1 with Vital Statistics that, you know, if  
 2 somebody was deceased, it would be in there  
 3 and that would be how they would--I never  
 4 really thought about it. I thought there'd be  
 5 some kind of connection between Vital  
 6 Statistics to the Cancer Registry and that  
 7 information would flow. Like I said, I never  
 8 really thought about it before that.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay, and other than consulting this person  
 11 with the blacked out name, the IT person, was  
 12 IT or Information Management otherwise  
 13 consulted to assist in coming up with a list  
 14 of patients?  
 15 MS. PREDHAM:  
 16 A. I went to the Health Care Corporation's IT  
 17 department to see what they could get from me--  
 18 from me--for me, and in our Meditech system,  
 19 they were able to get everybody who had an  
 20 ER/PR test ordered at that, but done, I  
 21 thought at the time, and with the exception of  
 22 1997 and part of 1998. So after that, they  
 23 could just--there would be no results, but it  
 24 would just be the name and the specimen  
 25 number.

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1 CHAYTOR, Q.C.:  
 2 Q. Okay, and in the long run, how complete did  
 3 that list prove to be?  
 4 MS. PREDHAM:  
 5 A. Well, it was fairly complete. We didn't--we  
 6 know now, of course, that there were instances  
 7 where the test wasn't ordered in Meditech,  
 8 which didn't have an impact on whether the  
 9 test was done or not. It just it wasn't  
 10 ordered, and therefore it didn't show up on  
 11 that list. But at the time, we weren't aware  
 12 that that was an issue.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and so your list though, and how you  
 15 went about compiling a list was somewhat  
 16 different from what Mr. Gulliver did?  
 17 MS. PREDHAM:  
 18 A. Well, he had the actual pathology reports. I  
 19 guess, the primary reason that I got involved  
 20 in this part at this point was just to  
 21 identify the patients that were deceased.  
 22 There was no easy way to determine that. Mr.  
 23 Gulliver wouldn't be able to determine that  
 24 from his access in the lab, so we were  
 25 exploring ways to identify those patients who



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1 were deceased, since our focus was on the  
 2 living.  
 3 CHAYTOR, Q.C.:  
 4 Q. And you were aware of Vital Statistics  
 5 yourself?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. You were aware of that registry, and did it  
 10 occur to you that that might be the most  
 11 accurate source to take your list or take Mr.  
 12 Gulliver's list and then cross reference that  
 13 with any information from Vital Statistics?  
 14 MS. PREDHAM:  
 15 A. Not at that time, it didn't.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay. So that appears to be it for the second  
 18 meeting on July 14th, and I'm just wondering  
 19 then, so out of the items discussed -  
 20 MS. PREDHAM:  
 21 A. I thought there was a list, a numbered list of  
 22 -  
 23 CHAYTOR, Q.C.:  
 24 Q. Numbered list.  
 25 MS. PREDHAM:

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1 A. - things to do at the end of that.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay.  
 4 MS. PREDHAM:  
 5 A. Or maybe I had that wrong.  
 6 CHAYTOR, Q.C.:  
 7 Q. Maybe there is, but maybe there's a gap  
 8 because I was thinking it was the end, because  
 9 there's nothing.  
 10 MS. PREDHAM:  
 11 A. Oh, there it is.  
 12 CHAYTOR, Q.C.:  
 13 Q. Here it is, okay. So even though there's a  
 14 gap, your item list starts on the next page.  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. So this belongs to that meeting?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay. So then, Don, I guess that's Dr. Cook,  
 23 is that correct?  
 24 MS. PREDHAM:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. Identify the patients?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. One and a half techs?  
 7 MS. PREDHAM:  
 8 A. I guess that's who he was able to get to  
 9 assist him to do that.  
 10 CHAYTOR, Q.C.:  
 11 Q. "Terry will find out -  
 12 MS. PREDHAM:  
 13 A. "That we"--I guess Terry will try to determine  
 14 the time lines in which we can do that.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and Dr. Cook, what does this say?  
 17 MS. PREDHAM:  
 18 A. "Don to follow up with colleagues regarding  
 19 why they have -  
 20 CHAYTOR, Q.C.:  
 21 Q. And do you recall then what that was about?  
 22 MS. PREDHAM:  
 23 A. No.  
 24 CHAYTOR, Q.C.:  
 25 Q. And thirdly, "controls were done every day and

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1 documented" and is -  
 2 MS. PREDHAM:  
 3 A. And I think this was the meeting I had a note  
 4 that I had to check on those controls.  
 5 CHAYTOR, Q.C.:  
 6 Q. Yes, and so you're going to go away and follow  
 7 up on that? Is that correct?  
 8 MS. PREDHAM:  
 9 A. Yeah.  
 10 CHAYTOR, Q.C.:  
 11 Q. And did you do that?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And what were you able to determine?  
 16 MS. PREDHAM:  
 17 A. That the--you know, I was told that the  
 18 controls were done every day, but the  
 19 documents weren't there to say that they were  
 20 done every day.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, and who did -  
 23 MS. PREDHAM:  
 24 A. Well, it wasn't what I expected them to be,  
 25 the documentation.

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1 CHAYTOR, Q.C.:

2 Q. Well, then perhaps you can tell us what did

3 you expect?

4 MS. PREDHAM:

5 A. Well, I expected that I would be able to tell

6 that slide number two would have control

7 number 24 run at the same time or run at that

8 time, or that was the control that was used.

9 CHAYTOR, Q.C.:

10 Q. That there'd be some--at least some cross

11 referencing to tell you which control slides

12 belonged to which patient slides?

13 MS. PREDHAM:

14 A. Right, yeah.

15 CHAYTOR, Q.C.:

16 Q. Okay, and you didn't find anything like that?

17 MS. PREDHAM:

18 A. No.

19 CHAYTOR, Q.C.:

20 Q. Okay, and who did you speak with that assured

21 you that controls were done every day?

22 MS. PREDHAM:

23 A. I think it was already noted that Mr. Gulliver

24 had told me that.

25 CHAYTOR, Q.C.:

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1 Q. Okay, but did you go away to--you were going

2 to go away to verify that they were done and

3 documented. So did you ask anyone else

4 whether or not the controls were done?

5 MS. PREDHAM:

6 A. I'm not sure if I went to Mr. Gulliver or Mr.

7 Dyer was back at that time, but I would have

8 gone to them to get the documents.

9 CHAYTOR, Q.C.:

10 Q. And did you speak with the technologists who

11 were actually carrying out the work and ask

12 them any -

13 MS. PREDHAM:

14 A. Not at that time.

15 CHAYTOR, Q.C.:

16 Q. Later on, you meet with them in August?

17 MS. PREDHAM:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. And did you ask them then in terms of what

21 were their practices in running controls?

22 MS. PREDHAM:

23 A. They did describe their practices for running

24 controls. For the life of me, I can't really

25 recall them right now, but my concern was that

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1 the documentation wasn't there to support that

2 practice or to support what they were saying.

3 There wasn't comprehensive documentation.

4 CHAYTOR, Q.C.:

5 Q. And in fact, was there any documentation that

6 you could link to controls, other than what

7 may or may not be recorded in a pathology

8 report for a given patient, and was there

9 anything else in the lab's own records that

10 dealt with controls?

11 MS. PREDHAM:

12 A. I don't think so. I'd have to go through my

13 notes and make sure, but that's -

14 CHAYTOR, Q.C.:

15 Q. And we'll come back to it again then when we

16 come to your note from your conversations with

17 them, okay. So also following from this

18 meeting, Don Cook was there, "a change in

19 sensitivity that affect results."

20 MS. PREDHAM:

21 A. And I guess that's the whole Ventana, but also

22 there were changes over the period of time

23 from '97 on in antigens or whatever in that

24 process and that, of course, each time

25 something got changed, the idea was to

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1 increase the sensitivity of the reporting, you

2 know, to increase the release of antigens, and

3 so it was that are our findings now consistent

4 with their findings? So is it--was there

5 changes over time. So would you expect a

6 certain amount of change or conversion over

7 time. If something was done in '97, would

8 you--if it was retested now, would you

9 automatically expect, because of changes that

10 have happened over that period of time, that

11 there would be a change in 2005.

12 CHAYTOR, Q.C.:

13 Q. Okay, and changes such as change in antibodies

14 is what you're thinking?

15 MS. PREDHAM:

16 A. Yeah, that type of, yeah.

17 CHAYTOR, Q.C.:

18 Q. Okay. "Are our findings consistent with their

19 findings?" and who are you referring to there?

20 MS. PREDHAM:

21 A. Well, I guess we were--anybody else who had

22 retested, were we finding that there were

23 different--were they finding there were

24 differences.

25 CHAYTOR, Q.C.:

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1 Q. Okay, and then five, six and seven, five is  
 2 hotline  
 3 MS. PREDHAM:  
 4 A. Coordination.  
 5 CHAYTOR, Q.C.:  
 6 Q. Coordination, and that's QSI, so Quality  
 7 Services.  
 8 MS. PREDHAM:  
 9 A. Quality and System Improvement.  
 10 CHAYTOR, Q.C.:  
 11 Q. Quality and System Improvement, so that's your  
 12 department is going to look after that.  
 13 MS. PREDHAM:  
 14 A. Yeah.  
 15 CHAYTOR, Q.C.:  
 16 Q. Media release, Susan Bonnell, I take it, is  
 17 going to look after that.  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. And then you've got "me" written by "HIROC and  
 22 other sites." So what were you to do?  
 23 MS. PREDHAM:  
 24 A. We were going to contact other pathology labs  
 25 across the country to see if they've had these

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1 issues, what they monitor, the positivity  
 2 rate, if they had come up with this issue and  
 3 did they go back and retest, that type of  
 4 information, and also, I was going to contact  
 5 the risk management side of HIROC and find out  
 6 if they had--this issue had come up before  
 7 with them.  
 8 CHAYTOR, Q.C.:  
 9 Q. And again--so in terms of the go forward on  
 10 the public announcement, a hotline to be set  
 11 up and Susan Bonnell, I guess, to work on a  
 12 media release, and at the end of the meeting  
 13 on July 14th, that was the plan?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. And there was no concerns expressed about  
 18 going public at this point in time?  
 19 MS. PREDHAM:  
 20 A. No.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay. Ms. Predham, in this meeting, and again  
 23 this is a meeting with the oncologists and  
 24 surgeons, was there any discussion in terms of  
 25 identifying the patients because Dr. Cook is

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1 to identify the patients--was there any  
 2 discussion about cutoffs and 30 percent and 10  
 3 percent?  
 4 MS. PREDHAM:  
 5 A. Well, I think that's--at that point in time,  
 6 there was so much information and so much that  
 7 it wasn't until, like, you actually stepped  
 8 back, so, okay, we're all agreed we going to  
 9 do this, and then we step back and say, okay,  
 10 all right, it's okay to say it in the  
 11 hypothetical, but now you got to have some  
 12 concrete structure around it. So it's all  
 13 right to have a bullet there and say that our  
 14 department is going to coordinate the hotline,  
 15 but we needed information, we needed to--you  
 16 know, we needed more detail, so there was a  
 17 lot of work that had to go into that. So the  
 18 same thing with Dr. Cook. So he's going to go  
 19 away and identify the patients, and that's  
 20 pretty clear, but then, of course, you've got  
 21 that, the cutoff, the treatment thing. So I  
 22 think that came after when he started to is  
 23 where do I start, what's the cutoffs for what  
 24 is negative.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay. So at this point in time, he was going  
 2 away to identify who was negative, and at some  
 3 point in time he needs further direction as  
 4 to, well, how are we defining negative?  
 5 MS. PREDHAM:  
 6 A. Exactly.  
 7 CHAYTOR, Q.C.:  
 8 Q. This issue here about Sloan-Kettering and they  
 9 just retested their lobulars and got cancer  
 10 and got 100 percent, and it was referenced  
 11 that there was going to be a publication, did  
 12 you ever have occasion later to search for  
 13 such a publication?  
 14 MS. PREDHAM:  
 15 A. Oh, I did. I never did find it. I haven't  
 16 recently, but at the time for that fall I did,  
 17 but I never found it.  
 18 CHAYTOR, Q.C.:  
 19 Q. So over that fall, you spent time looking for  
 20 this publication?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And did you have occasion to go back and ask  
 25 Drs. Laing or Dr. McCarthy any further

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1 information about it that might help you be  
 2 able to find such a publication?  
 3 MS. PREDHAM:  
 4 A. Oh, I asked them if they had heard if it was  
 5 out or if they had seen it or that--yeah.  
 6 CHAYTOR, Q.C.:  
 7 Q. What did they tell you?  
 8 MS. PREDHAM:  
 9 A. They hadn't at that point in time.  
 10 CHAYTOR, Q.C.:  
 11 Q. And did you ever have any further discussions  
 12 about this whole issue about Sloan-Kettering  
 13 having retested and a publication supposedly  
 14 coming forward?  
 15 MS. PREDHAM:  
 16 A. I think it came up again--it may have been,  
 17 you know, like, later when the Centre for  
 18 Health Information was over. I can remember  
 19 thinking I'm going to have to search for that  
 20 again now and see if it ever came up, or ask  
 21 somebody, but I don't think I ever did.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay.  
 24 MS. PREDHAM:  
 25 A. Nobody circulated and said, oh, look, here's

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1 the article that they were talking about.  
 2 CHAYTOR, Q.C.:  
 3 Q. And did you ever have any occasion to speak to  
 4 Dr. Williams about this issue of Sloan-  
 5 Kettering and what they may have done?  
 6 MS. PREDHAM:  
 7 A. Oh, we talked about it a lot at that time.  
 8 CHAYTOR, Q.C.:  
 9 Q. And did you ever contact Sloan-Kettering  
 10 yourself?  
 11 MS. PREDHAM:  
 12 A. No, I didn't.  
 13 CHAYTOR, Q.C.:  
 14 Q. And why not?  
 15 MS. PREDHAM:  
 16 A. I think that was one of the labs that Dr. Cook  
 17 contacted the pathologist at.  
 18 CHAYTOR, Q.C.:  
 19 Q. And what did you understand to have been the  
 20 outcome of Dr. Cook's contact with the  
 21 pathologist at Sloan-Kettering?  
 22 MS. PREDHAM:  
 23 A. I can't remember right now, I really can't  
 24 remember, but I don't think it was anything,  
 25 you know -

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1 CHAYTOR, Q.C.:  
 2 Q. Nothing germane to this issue?  
 3 MS. PREDHAM:  
 4 A. Yeah, nothing that contributed to it any  
 5 further.  
 6 CHAYTOR, Q.C.:  
 7 Q. And nothing that dissuaded you in your efforts  
 8 to try and find the publication?  
 9 MS. PREDHAM:  
 10 A. No.  
 11 CHAYTOR, Q.C.:  
 12 Q. Dr. Cook didn't come back and say, well, I've  
 13 spoken to the pathologist about that. Did you  
 14 understand that he even pursued that with  
 15 anyone, or was that a different issue?  
 16 MS. PREDHAM:  
 17 A. No, I thought he--I thought he did contact  
 18 Sloan-Kettering, but now that you're asking me  
 19 about it, I really can't remember the outcome  
 20 of that.  
 21 CHAYTOR, Q.C.:  
 22 Q. And what led you to believe that there was  
 23 such a publication?  
 24 MS. PREDHAM:  
 25 A. It was either Dr. McCarthy or Dr. Laing said

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1 that they said that they were going to publish  
 2 it.  
 3 CHAYTOR, Q.C.:  
 4 Q. Okay. If we could look, please, at 925,  
 5 please, page--I think we have it up there.  
 6 Yes, thanks, Registrar, page three, and I'll  
 7 just take you through Dr. Williams notes of  
 8 the same meeting, and general background and  
 9 he's got his own name by that specific  
 10 overview, "Dr. Cook issue of results  
 11 specifically in 2002", and there's reference  
 12 to the change in 1997, switching then to the  
 13 Ventana System, and "Dr. Laing, new  
 14 information, lobular CAs should all be ER  
 15 positive. Sloan-Kettering went from 75  
 16 percent to 100 percent positivity". I'll just  
 17 show you there's some issue as to whether--I  
 18 only have the typed version here, but there's  
 19 been some issue in terms of these handwritten  
 20 notes, if it's 75 percent of 95 percent that  
 21 should be. "As a result asked to--sorry, Dr.  
 22 Laing requested retesting" and strongly  
 23 positive results, "as a result, asked to  
 24 retest some patients, followed up on a lot of  
 25 patients from 2002. Sixteen out of 25 on

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1 retesting are positive. Doing another 38  
 2 patients in process, farm out testing outside  
 3 the province". So your note to farm out  
 4 testing outside the province, is this--do you  
 5 recall was this Dr. Laing suggesting farming  
 6 out the testing?  
 7 MS. PREDHAM:  
 8 A. No, I don't remember.  
 9 CHAYTOR, Q.C.:  
 10 Q. "Dr. Cook to get info on who to follow up",  
 11 and I believe that's it for Dr. Williams notes  
 12 on the meeting. So this issue here in terms  
 13 of Sloan-Kettering, new information, lobular  
 14 CA should all be ER positive, at Sloan-  
 15 Kettering went from 75 or 95 percent to 100  
 16 percent positive, is that consistent with what  
 17 you recall being said in the meeting about  
 18 Sloan-Kettering?  
 19 MS. PREDHAM:  
 20 A. And, I mean, I guess the--the fundamental  
 21 message was that all lobular cancers should be  
 22 ER/PR positive.  
 23 CHAYTOR, Q.C.:  
 24 Q. And you wrote in your note that that came  
 25 about as a result of retesting at Sloan-

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1 Kettering?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. And that's what you understood had happened?  
 6 I'm sorry, I know you're nodding, but we have  
 7 to pick it up on the transcript.  
 8 MS. PREDHAM:  
 9 A. Sorry. Yes.  
 10 THE COMMISSIONER:  
 11 Q. This farm out testing outside the province,  
 12 which is similar to something in your own note  
 13 -  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 THE COMMISSIONER:  
 17 Q. And what did you understand that to mean?  
 18 MS. PREDHAM:  
 19 A. I really can't remember other than, you know,  
 20 it was what we were trying to do--what we  
 21 ended up doing with Mount Sinai as getting  
 22 some place else to do it, I guess, in an  
 23 effort to be timely, and I'm not sure -  
 24 THE COMMISSIONER:  
 25 Q. Do you remember whether--were you talking at

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1 that time about the current testing, or were  
 2 you talking about the retesting?  
 3 MS. PREDHAM:  
 4 A. The retesting.  
 5 THE COMMISSIONER:  
 6 Q. So you recall this related to retesting?  
 7 MS. PREDHAM:  
 8 A. Yes, because we hadn't questioned--we really  
 9 didn't question Ventana until we looked at the  
 10 positivity results and they were--they were  
 11 high.  
 12 CHAYTOR, Q.C.:  
 13 Q. Then why would you be considering going  
 14 outside to do the retest?  
 15 MS. PREDHAM:  
 16 A. I can't--I really can't remember other than  
 17 the fact that maybe it was a time issue.  
 18 CHAYTOR, Q.C.:  
 19 Q. If we could look at P-0505, please. This is  
 20 page--this is the handwritten portion of the  
 21 July 14th, 2005 notes that Dr. Williams took,  
 22 and you'll see how kind he was to us to have  
 23 had them transcribed.  
 24 MS. PREDHAM:  
 25 A. Yes.

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1 CHAYTOR, Q.C.:  
 2 Q. And this is the note here, Dr. Laing, and then  
 3 there's a number of bullets.  
 4 MS. PREDHAM:  
 5 A. It does look like from 75 percent to 100  
 6 percent.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay. Do you recall any number being given  
 9 yourself in the meeting?  
 10 MS. PREDHAM:  
 11 A. Not now. You know, the message that I took  
 12 out of that was all the lobulars are--and they  
 13 weren't even--they were considering not even  
 14 testing them any more, and that was the  
 15 message I got.  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes. If we could have, please, P-0070. I  
 18 take it then, Ms. Predham, after this meeting  
 19 and the next few days, do you recall much  
 20 happening in terms of your involvement in the  
 21 issue?  
 22 MS. PREDHAM:  
 23 A. Well, at this time, the next day I did contact  
 24 the risk management department with HIROC. I  
 25 talked to our staff about we needed to set up

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1 a hotline, what information we needed to be  
 2 able to answer questions on the other end. So  
 3 we started, you know, having that process, and  
 4 the other thing we had to do was check across  
 5 the country. So we were coming up with what  
 6 questions to ask, what hospitals to check  
 7 with.  
 8 CHAYTOR, Q.C.:  
 9 Q. And you were checking across the country about  
 10 positivity rates, is that right?  
 11 MS. PREDHAM:  
 12 A. Well, pathology--there were specific things  
 13 that we were looking at, which include  
 14 positivity rates, if they had ever had any  
 15 issue like this, if they had any opportunity  
 16 to go back and retest, if they did retest,  
 17 that type of -  
 18 CHAYTOR, Q.C.:  
 19 Q. Okay, and the effort that you came across in  
 20 doing that, did you find anyone who had had  
 21 such a situation and found the need to go back  
 22 and retest?  
 23 MS. PREDHAM:  
 24 A. I think one they did a couple of retests, but  
 25 nobody had gone back and retested everybody.

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1 CHAYTOR, Q.C.:  
 2 Q. Okay. So you found in making inquiries across  
 3 the country, one place where you believe they  
 4 may have done one or two retests but nothing  
 5 that warranted a full massive retesting?  
 6 MS. PREDHAM:  
 7 A. Nothing like we had done.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay.  
 10 MS. PREDHAM:  
 11 A. I think one of them, and I'd have to refer to  
 12 the notes, I think one of them may have had a  
 13 conversion or something on that line.  
 14 CHAYTOR, Q.C.:  
 15 Q. And that's what caused them to go back and -  
 16 MS. PREDHAM:  
 17 A. But they didn't do a big retest like we did.  
 18 CHAYTOR, Q.C.:  
 19 Q. And if we could then--and this exhibit is an  
 20 e-mail from Susan--sorry, Deborah Thomas to  
 21 Susan Bonnell, the next day, Friday, July  
 22 15th, and she writes, "Hi Susan; Here's  
 23 today's update from Heather Predham". Do you  
 24 recall were you providing update to the  
 25 communications department?

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1 MS. PREDHAM:  
 2 A. No, I think we just had a conversation on the  
 3 phone and I had never seen this before--I  
 4 mean, I've seen it now, but I hadn't seen it  
 5 at that time, and I think I was just having  
 6 conversation with Deborah.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay, and she says, "Nancy is thinking about  
 9 how to implement a hotline". So that's what's  
 10 happening in your department, Nancy Parsons.  
 11 "Heather is proving an overview/synopsis for  
 12 George". I take it that's Mr. Tilley?  
 13 MS. PREDHAM:  
 14 A. Yes, Dr. Williams asked me to give an update  
 15 of our activity to date.  
 16 CHAYTOR, Q.C.:  
 17 Q. So Dr. Williams asked you to come up with  
 18 something for Mr. Tilley, and did you  
 19 understand he was already informed about the  
 20 issue?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And how long had he been brought into the  
 25 loop, how long had he been told?

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1 MS. PREDHAM:  
 2 A. I'm not sure, but I think--I had the  
 3 impression that he knew. I really can't  
 4 remember how long.  
 5 CHAYTOR, Q.C.:  
 6 Q. And "George wants to disclose this info to the  
 7 Board next week. Dr. Williams is trying to  
 8 talk him out of it". Do you recall telling  
 9 that or anything along those lines to Ms.  
 10 Thomas?  
 11 MS. PREDHAM:  
 12 A. No, and when I actually saw this at some point  
 13 in time when you showed it to somebody, I  
 14 can't recall it at all, and I certainly didn't  
 15 have that type of relationship that Dr.  
 16 Williams would be saying, you know, George  
 17 wants to give it to the board, but, you know,  
 18 I want to talk him out of it. I didn't have  
 19 that type of relationship with Dr. Williams,  
 20 so I can't imagine him even saying it to me.  
 21 CHAYTOR, Q.C.:  
 22 Q. So you have no idea where Ms. Thomas would  
 23 have got that and why she would have  
 24 attributed it to an update coming from you?  
 25 MS. PREDHAM:

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1 A. No, unless, you know--I have no idea.  
 2 CHAYTOR, Q.C.:  
 3 Q. Did you yourself have any concerns about the  
 4 board being informed about the issue?  
 5 MS. PREDHAM:  
 6 A. Absolutely not.  
 7 CHAYTOR, Q.C.:  
 8 Q. And did you hear anyone else express any  
 9 concern about informing the board?  
 10 MS. PREDHAM:  
 11 A. No.  
 12 CHAYTOR, Q.C.:  
 13 Q. "The lab has pulled names and numbers and  
 14 thinks that they may be able to do retesting  
 15 in-house, completing in about two weeks". So  
 16 is that consistent at this point in time?  
 17 Does that sound -  
 18 MS. PREDHAM:  
 19 A. Well, Ms. Thomas and Susan--Ms. Bonnell were  
 20 both at that meeting the day before where we  
 21 had questioned farming it out, so I guess this  
 22 was new information that had come out that  
 23 Friday morning.  
 24 CHAYTOR, Q.C.:  
 25 Q. "Terry Gulliver says he has documentation that

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1 shows positive controls were done daily  
 2 [Heather yet to see it]". So in terms of you  
 3 telling Ms. Thomas that Mr. Gulliver has  
 4 documentation, says he has such documentation,  
 5 do you recall that, did Mr. Gulliver tell you  
 6 that, that there is documentation that shows  
 7 positive controls were done daily?  
 8 MS. PREDHAM:  
 9 A. And I think that was in my notes before we had  
 10 seen, that that was the message that I had  
 11 gotten.  
 12 CHAYTOR, Q.C.:  
 13 Q. That he had told you that.  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. But you had yet to see it, and you've told us  
 18 that that remains the case to today?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. "Heather checking other hospitals to see if  
 23 they have any issues pertaining to this", and  
 24 you've told us about that. "Hoping this could  
 25 be just a matter of a dramatic improvement in

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1 technology [if indeed all controls were in  
 2 place]". Do you recall making such a  
 3 statement or expressing anything similar to  
 4 Ms. Thomas?  
 5 MS. PREDHAM:  
 6 A. well, I guess that was the thinking at the  
 7 previous meeting when we were talking about  
 8 changes that could have happened here. If we  
 9 had the controls, and my understanding at that  
 10 point of what these controls were, was that  
 11 the test worked, you know, and that this would  
 12 verify that the test did in fact work. So if  
 13 the test worked and now we're getting these,  
 14 could it be that those changes--and this ten  
 15 times increased level of sensitivity, that  
 16 could we be seeing this. So that was the  
 17 thinking at that time that we were hoping  
 18 that's what it could be. We hadn't ruled it  
 19 out to say that's what exactly it was, but  
 20 that's what we were hoping.  
 21 CHAYTOR, Q.C.:  
 22 Q. And "thinking we may want to release mid to  
 23 late next week", so that's meaning the public  
 24 release, I take it?  
 25 MS. PREDHAM:

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1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And everybody continued on to work towards  
 4 that end, I take it?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. If we could have then, please, P-0925, page  
 9 four.  
 10 THE COMMISSIONER:  
 11 Q. Sorry, before we leave this, "Heather is  
 12 providing an overview/synopsis for George",  
 13 now as I understand it, this is Friday, July  
 14 15th. Aside from that sort of heads up that  
 15 you had had in June, really your knowledge all  
 16 came from -  
 17 MS. PREDHAM:  
 18 A. That week.  
 19 THE COMMISSIONER:  
 20 Q. The 12th, 13th, 14th, and whatever you got the  
 21 morning of the 15th?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 THE COMMISSIONER:  
 25 Q. So was Dr. Williams--did you take the

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1 instruction from Dr. Williams to be--you were  
 2 to gather all the information that was  
 3 happening everywhere, or was yours a narrower  
 4 scope in terms of what you had to prepare for  
 5 Mr. Tilley?  
 6 MS. PREDHAM:  
 7 A. It was just, I guess, a summary of everything  
 8 we had done in that past week fundamentally.  
 9 It would be everything that had happened and  
 10 where we were from--I think it was from the  
 11 last letter that Dr. Cook wrote Dr. Williams.  
 12 THE COMMISSIONER:  
 13 Q. Okay, you, for some magic reason, got to be  
 14 the historian, keeping all the notes, and this  
 15 process?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 THE COMMISSIONER:  
 19 Q. Even though you might not have been involved  
 20 in the things that you would be covering in  
 21 this memo for Mr. Tilley?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 THE COMMISSIONER:  
 25 Q. Okay, thank you.

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1 CHAYTOR, Q.C.:  
 2 Q. And on page four, these again are Dr. Williams  
 3 notes, and the next day there's a meeting,  
 4 July 15th, 2005, and you're not in attendance  
 5 at this one, it's Mr. Gulliver, Drs. Cook and  
 6 Williams, and it says, "Reviewed meeting of  
 7 July 14th, 2005 re; identifying all patients,  
 8 and getting tests done as soon as possible.  
 9 Plan, pull one to two people to start process  
 10 and assign Mary. Dr. Cook to contact  
 11 pathologists in other centres to get cases  
 12 submitted. Terry advises that each patient  
 13 slide was processed along with the control  
 14 slide and the control slides were read, and no  
 15 reporting done until the control read as  
 16 positive. Dr. Carter to check with Mount  
 17 Sinai to see if change in sensitivity over  
 18 time with testing they used. Heather Predham  
 19 advised Terry Malone of the Cancer Registry.  
 20 He will have a list of all patients that are  
 21 currently alive and deceased. Dr. Cook to see  
 22 if Dr. Laing can provide article from Sloan-  
 23 Kettering on research in change of ER/PR  
 24 receptor testing". You're mentioned here in  
 25 terms of you had advised Terry Malone of the

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1 Cancer Registry?  
 2 MS. PREDHAM:  
 3 A. Well, I was advised to contact him. That was  
 4 the name that was redacted from the previous  
 5 page, and that he would get this list for me  
 6 of all the patients that are currently alive  
 7 and deceased.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and so that's what this is in reference  
 10 to?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. We've already talked about that, and the  
 15 information here that Terry advised each  
 16 patient's slide was processed along with the  
 17 control slide, and the control slides were  
 18 read and no reporting done until control read  
 19 as positive, were you provided with similar  
 20 information from Mr. Gulliver to that effect?  
 21 MS. PREDHAM:  
 22 A. That was the information that I was looking  
 23 for and documentation.  
 24 CHAYTOR, Q.C.:  
 25 Q. And--okay, so that's the same information that

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1 you were trying to find documentation to  
 2 substantiate?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. If we could have, please, P-0323, and this is  
 7 a memo from Dr. Williams to Mr. Tilley, and it  
 8 is an update on ER/PR receptor testing, and  
 9 it's a two page document. Is this the  
 10 document that you prepared for Mr. Tilley, the  
 11 update for Mr. Tilley?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And if we could have then, please, P-01930,  
 16 and this is July 18th, 2005. It's from  
 17 yourself to Drs. Williams, Cook, and Mr.  
 18 Gulliver, and cc'd to Denise Dunn. I take it  
 19 that was Dr. Williams' assistant, is that  
 20 correct?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. Update for Mr. Tilley. "Hi, here's the update  
 25 for Mr. Tilley. Please review it and add



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1 anything you feel necessary. I'm not sure who  
 2 this should go from, so I left it blank. I  
 3 didn't include any information, re; Dr.  
 4 Ejeckam's memos ... should we? Thanks,  
 5 Heather". You'll see then attached here,  
 6 here's your draft left blank as to who it's  
 7 coming from, and the two pages. Ms. Predham,  
 8 why didn't you include any information re; Dr.  
 9 Ejeckam's memos?  
 10 MS. PREDHAM:  
 11 A. Well, I--the fact that Dr. Ejeckam had stopped  
 12 testing was mentioned in Dr. Cook's letter  
 13 from May 24th, and the memos--Dr. Williams  
 14 wanted an update of our activity, I guess,  
 15 that's how he phrased it, and Dr. Ejeckam's  
 16 memos were significant, but they weren't  
 17 really affecting the activity as to that date.  
 18 The other part of it is that meeting where we  
 19 saw that memo, I knew that Dr. Williams hadn't  
 20 seen that memo before, and he was quite  
 21 concerned about it, and I didn't know how he  
 22 wanted to approach that with Mr. Tilley with  
 23 Mr. Tilley or not; if he wanted me to just put  
 24 it in here, and--I really didn't know what to  
 25 say about them.

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1 CHAYTOR, Q.C.:  
 2 Q. Okay. So, up to this point in time, the May  
 3 24th letter, as you say, have reference to Dr.  
 4 Ejeckam's memos and -  
 5 MS. PREDHAM:  
 6 A. Well, had reference to -  
 7 CHAYTOR, Q.C.:  
 8 Q. Reference to that that had happened with Dr.  
 9 Ejeckam.  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. And that letter was between, from Dr. Cook to  
 14 Dr. Williams.  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. And Mr. Tilley wouldn't have been aware of  
 19 that correspondence.  
 20 MS. PREDHAM:  
 21 A. I think I was attaching it to this update.  
 22 CHAYTOR, Q.C.:  
 23 Q. So, you were going to give Mr. Tilley a copy  
 24 of the May 24th correspondence plus this  
 25 update.

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And did you ultimately do that?  
 5 MS. PREDHAM:  
 6 A. I sent this over to Dr. Williams and I assume  
 7 that that was what was done.  
 8 CHAYTOR, Q.C.:  
 9 Q. So, you sent this over and you thought Dr.  
 10 Williams would include the May 24th  
 11 correspondence.  
 12 MS. PREDHAM:  
 13 A. Can you just go back to the--didn't I say I  
 14 had attached that May 24th letter?  
 15 CHAYTOR, Q.C.:  
 16 Q. On this?  
 17 MS. PREDHAM:  
 18 A. Can you just go back up? Oh, I thought I  
 19 attached it. That was--my understanding was  
 20 this was an update from that letter for Mr.  
 21 Tilley. So, it wouldn't make much sense for  
 22 him if he didn't see the update because I'm  
 23 saying this is what happened since this memo  
 24 occurred.  
 25 CHAYTOR, Q.C.:

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1 Q. Yes. And if we go back then to 0323.  
 2 REGISTRAR:  
 3 Q. (Inaudible).  
 4 CHAYTOR, Q.C.:  
 5 Q. Oh, look at that. Thank you.  
 6 MS. PREDHAM:  
 7 A. Oh, it is attached.  
 8 CHAYTOR, Q.C.:  
 9 Q. And it says attached. This is your final  
 10 version?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. So, the reference to Dr. Ejeckam is the  
 15 reference in the May 24, 2005 letter.  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. And in terms of including the memos, you're  
 20 saying that Dr. Williams haven't see them  
 21 himself until the meeting of--is that the July  
 22 12th meeting.  
 23 MS. PREDHAM:  
 24 A. 14th.  
 25 CHAYTOR, Q.C.:

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1 Q. 14th meeting, he hadn't seen them before,  
 2 himself. So, that's the same day that you see  
 3 the memo.  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And that was just the July 19th memo at that  
 8 point?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And if we could go back then to P-1930, go  
 13 back to page one, your e-mail. And you're  
 14 referring here to plural memos. So, by this  
 15 point on July 18th, are you aware of more than  
 16 one memo?  
 17 MS. PREDHAM:  
 18 A. Well, I knew that he had sent one around to  
 19 pathologists. I don't think I had seen it at  
 20 that point in time, but I did get a copy of it  
 21 at that time, but he did send a memo to  
 22 pathologists.  
 23 CHAYTOR, Q.C.:  
 24 Q. So, the May 2nd, I believe it is, May 2nd memo  
 25 that you ultimately end up with, you have the

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1 June 19th one as of July 14th.  
 2 MS. PREDHAM:  
 3 A. Right.  
 4 CHAYTOR, Q.C.:  
 5 Q. And you end up with the May 4th or 2nd,  
 6 whichever it is, you have that by the time  
 7 you're writing this?  
 8 MS. PREDHAM:  
 9 A. I may have. I may have--I got it somewhere in  
 10 that period of time, but I can't remember  
 11 when, but I did know it existed.  
 12 CHAYTOR, Q.C.:  
 13 Q. And you're asking should you include it  
 14 because you're not sure whether or not this is  
 15 how you want, how Dr. Williams would want Mr.  
 16 Tilley to learn of the issue?  
 17 MS. PREDHAM:  
 18 A. Well, you know, Dr. Williams asked me to give  
 19 an update of our activity. And I really  
 20 didn't know--I didn't know how to address it,  
 21 how to put it in there or whether it should go  
 22 in this route or whether Dr. Williams wanted  
 23 to tell Mr. Tilley directly.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay. And you said when Dr. Williams received

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1 the memo himself on July 14th, he was  
 2 concerned about it.  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. Yes. And I guess that was, again, the same  
 7 sort of concerns you had given the language  
 8 that was used in it.  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. So, was that your concern about Mr. Tilley  
 13 reading the memo and the language that's used  
 14 in there and how serious the message is that  
 15 Dr. Ejeckam is conveying in the memos.  
 16 MS. PREDHAM:  
 17 A. Well, I guess it wasn't something you'd like  
 18 to send in the internal mail for him to sit  
 19 down and say oh, by the way, this--you know,  
 20 this got sent two years ago. I think you'd  
 21 like to give it some kind of context when you  
 22 gave it to him.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay. The May 24th letter insofar as that  
 25 referred to what had happened, that wouldn't

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1 be sufficient context?  
 2 MS. PREDHAM:  
 3 A. Well, I didn't know and that's why I was  
 4 asking the question.  
 5 THE COMMISSIONER:  
 6 Q. Ms. Chaytor, it's five after five, so when you  
 7 get an appropriate spot, we'll break.  
 8 CHAYTOR, Q.C.:  
 9 Q. If we could look then, please, at P-2950.  
 10 Okay. And this is a response back from Mr.  
 11 Gulliver to you. "Heather, looks fine to me.  
 12 I would not include Dr. Ejeckam's letter. I  
 13 think Dr. Williams or Dr. Cook should send the  
 14 memo". And what did you understand Mr.  
 15 Gulliver to be telling you in his response?  
 16 MS. PREDHAM:  
 17 A. That he read over the letter, the content was  
 18 fine, that he didn't think Dr. Ejeckam's  
 19 letter should be included and that either Dr.  
 20 Williams or Dr. Cook should sign it.  
 21 CHAYTOR, Q.C.:  
 22 Q. Should sign the memo that's going out.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And did you also receive a response  
 2 from Dr. Cook?  
 3 MS. PREDHAM:  
 4 A. I spoke to him on the phone.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay. And what did Dr. Cook tell you?  
 7 MS. PREDHAM:  
 8 A. I think, as I remember, he wanted it left to  
 9 Dr. Williams about Dr. Ejeckam's letter, about  
 10 how he wanted to handle that.  
 11 CHAYTOR, Q.C.:  
 12 Q. I'm sorry?  
 13 MS. PREDHAM:  
 14 A. He left it to Dr. Williams to decide how he  
 15 wanted to handle that. And there was some  
 16 questions that I had in the memo and he  
 17 answered those for me.  
 18 CHAYTOR, Q.C.:  
 19 Q. And did you have any response from Dr.  
 20 Williams in terms of your query about whether  
 21 or not to include Dr. Ejeckam's memos?  
 22 MS. PREDHAM:  
 23 A. I must have, since I didn't include it. So,  
 24 he must have told me that he was going to  
 25 handle it another way, but I don't remember

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1 talking to Dr. Williams about it actually.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay. And so you didn't include the memos.  
 4 You included the letter of May 24th.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay. And if we could look at P-0300 please?  
 9 And this is an e-mail of July 18th, 2005,  
 10 Heather Predham to Dr. Williams and it's ER/PR  
 11 Receptor letter and you say you've "heard back  
 12 from Dr. Cook and Terry Gulliver re: the  
 13 letter and the changes have been made. Both  
 14 agree that it should come from you. I was  
 15 speaking to Deborah Thomas today and the  
 16 Department of Health has been notified and is  
 17 now involved. They would like a letter sent  
 18 to each woman outlining the problem and the  
 19 steps we are taking to address it. That draft  
 20 letter will have to be seen by our lawyer  
 21 first, of course. And I'll take up the rest,  
 22 this part of the correspondence with you, but  
 23 I just wanted to--in terms of, I take it, this  
 24 is the update going to Mr. Tilley, the first  
 25 part of this e-mail.

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1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And do you know whether or not--so, the update  
 5 that you did for Mr. Tilley that went or you  
 6 did for Dr. Williams and it went on to Mr.  
 7 Tilley, it included the May 24th  
 8 correspondence with the reference to Dr.  
 9 Ejeckam. And do you know whether or not Mr.  
 10 Tilley, at any subsequent point in time,  
 11 received Dr. Ejeckam's memos?  
 12 MS. PREDHAM:  
 13 A. I don't know for a fact. I just assumed that  
 14 he did.  
 15 CHAYTOR, Q.C.:  
 16 Q. And did you see Dr. Ejeckam's memos as being  
 17 an important piece of information from Mr.  
 18 Tilley as CEO to have regarding the ER/PR  
 19 issue?  
 20 MS. PREDHAM:  
 21 A. It was important because it was, you know, it  
 22 didn't affect what we were doing now, but it  
 23 was a red flag that could have been picked up  
 24 before.  
 25 CHAYTOR, Q.C.:

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1 Q. So, you would have given him the memos or at  
 2 least had--made sure that it came to his  
 3 attention in the appropriate manner.  
 4 MS. PREDHAM:  
 5 A. Oh, no problem. I mean, I'd already sent it  
 6 to Ms. Pilgrim, Dr. Williams had it. So, I  
 7 mean, members of executive team had copies of  
 8 it.  
 9 CHAYTOR, Q.C.:  
 10 Q. Thank you, Commissioner.  
 11 THE COMMISSIONER:  
 12 Q. 9:30 in the morning.  
 13 Upon conclusion at 5:11 p.m.

1 CERTIFICATE

2 I, Judy Moss, hereby certify that the foregoing is  
3 a true and correct transcript in the matter of the  
4 Commission of Inquiry on Hormone Receptor Testing,  
5 heard on the 16th day of October, A.D., 2008 before  
6 the Honourable Justice Margaret A. Cameron,  
7 Commissioner, at the Commission of Inquiry, St.  
8 John's, Newfoundland and Labrador and was  
9 transcribed by me to the best of my ability by  
10 means of a sound apparatus.

11 Dated at St. John's, Newfoundland and Labrador  
12 this 16th day of October, A.D., 2008  
13 Judy Moss

Inquiry on Hormone Receptor Testing

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Inquiry on Hormone Receptor Testing

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