COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

September 25, 2008

Appearances:

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

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

Peter Browne . . . . . Doctors Kara Laing et al

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

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

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

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Certificate

THE COMMISSIONER:
Q. Mr. Coffey?
COFFEY, Q.C.:
Q. Thank you, Commissioner. Commissioner, Mr. Rick Singleton is back to continue his testimony.
THE COMMISSIONER:
Q. Welcome back, Mr. Singleton. It's been awhile.
MR. SINGLETON:
A. Thank you, thank you.
COFFEY, Q.C.:
Q. He was last here in June. Commissioner, at the time I had concluded my examination and you had canvassed the room, in fact, at the time, as the estimates of time that various counsel might be with Mr. Singleton. I'm going to ask leave of you to enter one further exhibit in relation to Mr. Singleton which we received quite sometime after he testified, we received it within the past, I believe, two weeks, arising out of a matter that we only became aware of, I believe, during Dr. Laing's testimony. So if I could, Commissioner, ask some questions on it?

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THE COMMISSIONER:
Q. All right. What exhibit is that?
COFFEY, Q.C.:
Q. Exhibit is Exhibit P-2826.
THE COMMISSIONER:
Q. 2826. That's been distributed, I presume, to other counsel?
COFFEY, Q.C.:
Q. Yes, it has, Commissioner.
THE COMMISSIONER:
Q. Entered.
EXHIBIT ENTERED AND MARKED P-2826.
COFFEY, Q.C.:
Q. And, Commissioner, if I might be given leave to ask Mr. Singleton some questions concerning this?
THE COMMISSIONER:
Q. Yes.
MR. RICHARD SINGLETON (RESUMES STAND) EXAMINATION BY BERNARD COFFEY, Q.C. (CONTINUED)
COFFEY, Q.C.:
Q. Thank you. Mr. Singleton, of course, you've told the Commissioner before about your role in relation to ethics, ethics consultations within Eastern Health.

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MR. SINGLETON:
A. Um-hm.
COFFEY, Q.C.:
Q. Okay?
MR. SINGLETON:
A. Yeah.
COFFEY, Q.C.:
Q. This document, if we could, please, Registrar, bring up Exhibit P-2826? There it is on the screen, Mr. Singleton. It's entitled "Ethics Consultation Documentation Memo." It's to Patricia Pilgrim as COO from yourself. You describe yourself as a facilitator. The date is April 30th, 2008, it's "Re Ethics Consultation Summary." And then the document reads, "The discussion was held at HSC administration meeting room to discuss appropriate actions to respond to concerns and issues presented from patient and family concerns regarding the ER/PR situation. Present for the discussion are Patricia Pilgrim, Cathie Doran, Daryl Pullman, Dan Simmons, Jennifer Flynn, Nancy Parsons, Sharon Smith, Pam Elliott, Deborah Collins" and yourself. Well, Ms. Pilgrim, I take it, is

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the person to whom this is--memo is directed. She is the chief operating officer?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Or one of them?
MR. SINGLETON:
A. Yeah.
COFFEY, Q.C.:
Q. And Ms. Doran is, Cathie Doran?
MR. SINGLETON:
A. I believe she's probably with the Centre for Health Information. I'm not sure what centre she's with, not exactly sure.
COFFEY, Q.C.:
Q. Might she be a communications person, do you know?
MR. SINGLETON:
A. She could be. I know Deborah Collins is.
COFFEY, Q.C.:
Q. So Deborah Collins is listed there. Daryl Pullman?
MR. SINGLETON:
A. He's an ethicist.
COFFEY, Q.C.:

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Q. Ethicist. Mr. Simmons is counsel for Eastern Health, he's here in the room. Jennifer Flynn?
MR. SINGLETON:
A. An ethicist.
COFFEY, Q.C.:
Q. She works with?
MR. SINGLETON:
A. She's part of the contract we have with the medical school and Eastern Health.
COFFEY, Q.C.:
Q. Okay. And does Mr. Pullman fall into that category, as well?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Nancy Parsons?
MR. SINGLETON:
A. A patient relations officer.
COFFEY, Q.C.:
Q. She's the lady, in fact, who testified here yesterday.
MR. SINGLETON:
A. Yesterday, yeah.
COFFEY, Q.C.:

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Q. Sharon Smith?
MR. SINGLETON:
A. Program director for cancer care.
COFFEY, Q.C.:
Q. And Pam Elliott?
MR. SINGLETON:
A. Quality and risk management director.
COFFEY, Q.C.:
Q. And then you go on to write, "Since the start of Commission of Inquiry there has been a considerable increase in calls from patients and families requesting information regarding the status of their tests and diagnosis. Some cases individuals claim there has been no contact made with them. When their health record is reviewed with them, they remember that there had been a conversation and in some cases they did not realize or understand that the contacts and conversations were about their ER/PR status. Numerous factors could have contributed to this confusion. The groups discussed--the group," I'm sorry, "discussed the ethical issues and responsibility to deal with this situation. There was consensus that since we know there

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is heightened anxiety resulting from the confusion about the ER/PR testing that we ought to take steps to clarify the matter to the extent possible. The Eastern Health core values of respect and integrity prompt us to take these steps. The principle of beneficence to do good and nonmaleficence," I'm sorry, "do no harm. Further support to take action to provide information to those impacted, the principle of justice leads to acts to correct wrong or misleading information that is causing distress, perhaps interfering with important therapeutic relationships and complicating the health and wellbeing of the individuals." It is recommended that letters be prepared for everyone in the four major categories of patients tested in the time period being reviewed by the Commission of Inquiry. Patients tested with no change, patients tested with change in ER/PR value and no change of treatment, patients tested with change in ER/PR value and change of treatment and patients retested who ought not to have been retested. The letters should be tailored

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to the individuals in each category to review the details of their category and the previous contacts and efforts to contact regarding disclosure of their individual cases. The letter should also"--that should be "contain a number and e-mail for further contact."
MR. SINGLETON:
A. Right.
COFFEY, Q.C.:
Q. It continues, "It was further recommended that subsequent to the mailing of the letters and reasonable time for delivery a substantial effort be made to inform the public that the individual letters above have been distributed and to provide a number for individuals to call if they think they ought to have received a letter and have not yet received one. We know that families of deceased patients have been altered of relevant matters and we will allow them to make contact when and as they so desire. The group had some discussion of ways that Eastern Health might offer" some--"more," I'm sorry, "more support to the individuals and families impacted by ER/PR. There was no specific plan put in place but there was a

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clear consensus that Eastern Health should pursue some means to provide support directly or indirectly to those impacted." And there's a space for your signature, Rick Singleton, Ethics Consultation Facilitator. Now, Mr. Singleton, can you tell the Commissioner, please, when it was that you provided this to be passed on to the Commission, when did that happen?
MR. SINGLETON:
A. Oh, gee, I didn't really pass it on to the--I didn't give it to anyone to pass on to the Commission. I sent it to Pat Pilgrim.
COFFEY, Q.C.:
Q. Okay.
MR. SINGLETON:
A. And so she would have been the one who would forward it on, I think.
COFFEY, Q.C.:
Q. So then in relation to that, this particular copy is not signed, the version we have here.
MR. SINGLETON:
A. Probably because it went through e-mail.
COFFEY, Q.C.:
Q. Okay, so but it was sent to Ms. Pilgrim by

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yourself?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. And it would have been sent--it's dated April 30th, 2008. Do you know when it was sent?
MR. SINGLETON:
A. Oh, I expect within, you know, around that time, within a week of that date, for sure.
COFFEY, Q.C.:
Q. Okay. And was that the date of the actual meeting itself?
MR. SINGLETON:
A. No. I think the meeting was probably on the-- I'm not sure, I could have checked it, actually, in my calendar. But if it wasn't that date, it was a few days before that.
COFFEY, Q.C.:
Q. Before that?
MR. SINGLETON:
A. Yeah.
COFFEY, Q.C.:
Q. Could you tell the Commissioner, please, Mr. Singleton, about how this came about, this particular meeting?

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MR. SINGLETON:
A. That one came about, that's why it's addressed to Ms. Pilgrim, that she requested that we meet and have a discussion, as we have over a variety of issues within Eastern Health. And the ethics consultation process brings together a kind of multidisciplinary or a variety of people with different perspectives on matters to discuss things. And so she asked that we have a meeting to discuss what next steps or what other steps we might consider in terms of following up with families as this event has been unfolding.
COFFEY, Q.C.:
Q. Do you recall when it was that she contacted you about doing so?
MR. SINGLETON:
A. I expect it would have been sometime certainly in April. It usually takes a bit of time to get people together, and in that case her office was actually giving a great lift with getting the event organized. And when we are putting together an ethics consultation, the person that requests it, I usually have a discussion with them about how needs to be

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involved and sometimes suggest, well, if there are others, bring them along, as well. So that's how things come about.
COFFEY, Q.C.:
Q. So your recollection is that sometime in April of 2008 Ms. Pilgrim contacted you?
MR. SINGLETON:
A. Yes, um-hm.
COFFEY, Q.C.:
Q. And spoke to you about possibly having an ethics consultation meeting?
MR. SINGLETON:
A. Yeah.
COFFEY, Q.C.:
Q. Concerning what?
MR. SINGLETON:
A. It was concerning the follow-up letters, communication with families, you know, in that general kind of area. I'm not exact--I don't remember exactly what words were used in the description, but generally it was about the follow up and communications with patients, I should have said, and -
COFFEY, Q.C.:
Q. Now, then, who then decided, because I've just

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gone through the list of--I take it this is the list of people who participated?
MR. SINGLETON:
A. Um-hm.
COFFEY, Q.C.:
Q. And their various occupations or titles or backgrounds. Who chose them and why were they chosen to participate?
MR. SINGLETON:
A. Well, I certainly would have been considering who would need to be involved in that type of a consult, who would we want to have and need to have and who would be informed about the particular matter to contribute to the discussion and inform the ethics discussion. So I would have been certainly significant in the selection and then in the discussion with Pat. And then part of the challenge after that is finding who is available. Sometimes we'd invite a person and they may wind up having to--you know, they'd get someone else from their service area to attend and what have you.
COFFEY, Q.C.:
Q. And was there any individual or individuals

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that you were not--you wanted to have come but were not able to arrange?

MR. SINGLETON:

A. I don't remember right now.

COFFEY, Q.C.:

Q. Okay, and here in the group it's listed, I take it there are no patients or people who would actually represent a patient or the patients' view, just listing, looking at the list.

MR. SINGLETON:

A. No. Yeah.

COFFEY, Q.C.:

Q. Is there any reason why that's so?

MR. SINGLETON:

A. Yeah, because that's the phase where we were with the discussion about this matter, to look at what Eastern Health was doing and would do as it continued with its efforts to make contacts and to follow up on things that had already been done and the discussion of things that had been undertaken and the success with those things undertaken and what have you. And so it was really about an internal matter at that point.

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COFFEY, Q.C.:

Q. And what was your understanding of why an ethics consult was being sought in this regard?

MR. SINGLETON:

A. I think it's because we've had success with creating a forum where there's a good broad discussion, quite often with people who have not been part of the issue as hands on, certainly, as others who would be participating in it. And it's to give opportunity to, I suppose, look at the matter to what we would describe in talking about ethics, look at it through an ethics lens in terms of principles and values and those types of things to kind of gage the rightness of what we were doing and the approach that's being taken and why things are being done the way they are from the ethics perspective. There's lots of other reasons why things are done they way they are, as well, but at least to have that lens put on the matter.

COFFEY, Q.C.:

Q. And -

MR. SINGLETON:

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A. And I think I'd add to it that generally speaking when we've had those types of discussions on wide array of matters within Eastern Health and the previous organizations, that generally most people found them to be a quite worthwhile undertaking and quite informative.

COFFEY, Q.C.:

Q. Sir, this is the, as it's styled, the Ethics Consultation Summary, is what it is?

MR. SINGLETON:

A. Yes.

COFFEY, Q.C.:

Q. Was this circulated to anyone--back up a bit. Is this the final version, do you know?

MR. SINGLETON:

A. Yes.

COFFEY, Q.C.:

Q. Okay. Was it circulated, was a draft circulated first to anybody?

MR. SINGLETON:

A. Usually what I do with them is send a copy to the person who was--to the ethicist or ethicists who are there to ask them to have a read through to make sure that we've captured,

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you know, the ethics perspectives accurately. And they'll usually respond to me within a--I asked for a fairly quick turnaround on it. And sometimes I distributed to others who participated to make sure that if they had thoughts and ideas they contributed or in some cases people are there as a resource person to inform us about matters that others wouldn't have a perspective on, so make sure that it's factually correct and what have you.

COFFEY, Q.C.:

Q. So you've already told, the last time you testified, the Commissioner about the June, 2006 consultation in this regard. This is another one, April, 2008 in relation ER/PR. Have there been any others?

MR. SINGLETON:

A. No, not that I've been--no, there's has--I can say that, yeah.

COFFEY, Q.C.:

Q. Now, in relation to this particular meeting, we have this memo. Are there any other documents that would exist in relation to this meeting, like the preparation for it, notes on what was said, drafts exchanged, comments

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exchanged?
MR. SINGLETON:
A. No, I--you know, there might be a few handwritten notes that individuals would have, you know, as people go about participating in meetings and so on, but -
COFFEY, Q.C.:
Q. How about yourself, would you -
MR. SINGLETON:
A. No, I don't have, no.
COFFEY, Q.C.:
Q. So if one was to go to your office, you'd find electronically -
MR. SINGLETON:
A. Yeah, I mean, I may have a few handwritten notes, as I had on the previous one, yeah.
COFFEY, Q.C.:
Q. Okay, and how about e-mails setting this up and discussing who might be there and so on, as you had for the previous one?
MR. SINGLETON:
A. Yes, I expect so, yeah.
COFFEY, Q.C.:
Q. There would be something like that?
MR. SINGLETON:

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A. Yeah.
COFFEY, Q.C.:
Q. If I could ask that, please, that perhaps you gather what does exist up and provide it to Mr. Simmons who can pass it along to ourselves? In relation to the actual meeting itself, do you recall how long the meeting went, how long it was?
MR. SINGLETON:
A. I know it was in the afternoon. I expect it was probably an hour, an hour and a half.
COFFEY, Q.C.:
Q. And I note that Ms. Parsons was there, Nancy Parsons?
MR. SINGLETON:
A. Um-hm.
COFFEY, Q.C.:
Q. And at the time what was your understanding of the nature of her involvement in this matter?
MR. SINGLETON:
A. I understood that she was the patient relations officer and was handling calls from people who were calling and from their department, making contacts with people, as well.

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COFFEY, Q.C.:
Q. And do you recall what, if anything, she said at the meeting?
MR. SINGLETON:
A. Nothing specific, no.
COFFEY, Q.C.:
Q. Okay. Do you know or do you recall if at the meeting any concern was raised or the issue was raised at all concerning patients who were originally ER positive and were not retested?
MR. SINGLETON:
A. No, I -
COFFEY, Q.C.:
Q. Did that come up at all?
MR. SINGLETON:
A. I don't remember it, no.
COFFEY, Q.C.:
Q. And the reason I raise that, Mr. Singleton, I appreciate, you know, your role in this, you're a facilitator for ethics consultation as opposed to somebody involved in the nitty gritty of responding to the ER/PR issue. But the Commissioner has heard a certain amount on this, including from Ms. Parsons, about concerns that certainly Ms. Parsons heard from

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patients, some patients who were ER positive but who didn't know they were ER positive initially and she had to tell them that or who were confused or who were just concerned otherwise.
MR. SINGLETON:
A. Um-hm.
COFFEY, Q.C.:
Q. They knew their status but were concerned about their test results. So I wanted to ask you, because when I look at reading this, and I've taken you through it now this morning, it was not at all contemplated that any letters be sent to the ER positive patients, this consultation didn't deal with them, did it?
MR. SINGLETON:
A. No. You know, by my summary of it and the review by the people who reviewed it before we finalized it or before I finalized it, it wasn't--but I don't remember there being--like, the scope of the discussion, as I remember it, was essentially about making sure that there was a tailored letter that went to the people and then the process of, you know, making it a public announcement to make sure

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that if there were people who think that they ought to have received a letter and hadn't, that they could follow up and that type of stuff.

COFFEY, Q.C.:

Q. And I take it then, looking at this, it was directed at how the patients who had been involved in the actual retesting process, because this is involved in the sense of were ER negative?

MR. SINGLETON:

A. Um-hm.

COFFEY, Q.C.:

Q. Or in any case, for whatever reason, had their samples retested?

MR. SINGLETON:

A. Yes, yeah.

COFFEY, Q.C.:

Q. Directed at communicating, Eastern Health communicating with them?

MR. SINGLETON:

A. Yes.

COFFEY, Q.C.:

Q. That that's what this was directed at?

MR. SINGLETON:

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A. Yes.

COFFEY, Q.C.:

Q. To your knowledge the subject matter wasn't raised at all about possibly communicating with breast cancer patients at large?

MR. SINGLETON:

A. No.

THE COMMISSIONER:

Q. Mr. Singleton, what's the ethical issue in this case?

COFFEY, Q.C.:

Q. Yes, and that -

MR. SINGLETON:

A. Pardon me?

THE COMMISSIONER:

Q. What's the ethical issue?

MR. SINGLETON:

A. Well, I think it was, the ethics consult was to, I suppose, fortify the approach that was being considered to undertake to make, have further communications and to be intentional about making the tailored letters to people and those kinds of things. And for the most part I think that people who were there generally agreed that, yes, this is something

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that ought to be done and, you know, to move forward in this way makes good sense and what have you.

THE COMMISSIONER:

Q. So when Ms. Pilgrim came to you asking you to do this, there was a proposal for consideration by the group, was there?

MR. SINGLETON:

A. No, I don't think that it was--I think, no, there was--that wasn't the way that I received it. It was to sit and have the discussion. And as we got into the discussion about, you know, what do we need to do or how should we approach further follow up.

THE COMMISSIONER:

Q. Was the discussion as broad as do we need to do anything and what are our options or was the discuss more focused? I'm really having trouble understanding why you needed an ethics consult.

MR. SINGLETON:

A. Okay, yeah, yeah.

THE COMMISSIONER:

Q. Perhaps, you know, you were being used as a facilitator for another purpose, but I really

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don't see this as an ethics consult.

MR. SINGLETON:

A. Okay.

THE COMMISSIONER:

Q. And that's what, I suppose, I need your help with.

MR. SINGLETON:

A. Yeah. There were no options that were laid on the table to say this is what we are doing or what we should do, or should not do, and so on. It was kind of a clean slate in many ways, but it didn't take long into the discussion once, you know, we were lying out kind of where--that there was feedback of a variety of sorts, people not being communicated with, or being confusion, or people had contacts and didn't realize that that's what they were being told. So then really our discussion and the ethics part of it was really about the obligation to move forward and try and clarify confusion and to make an effort to verify for everyone's sake that people have as much information and the right information that pertains to their treatment or changes that need to be made or

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whatever the case might be.
THE COMMISSIONER:
Q. But when you started out to do this, did you believe that it was a consult for the purpose of determining what ethically should be done, given the circumstances at the time, or was it a question of whether or not from the perspective of ethics one or another of many approaches might be more appropriate, or were you just being asked to help people in a conversation about the next step?
MR. SINGLETON:
A. Yeah, well, I think the--usually ethics consults wind up being a bit of all of those things.
THE COMMISSIONER:
Q. Uh-hm.
MR. SINGLETON:
A. But I think there was genuine concern that we have an ethics lens, you could call, an ethics discussion on the matter. That's why we had, you know, an ethicist or two ethicists available for this case, but--mainly because they were available. Typically we would have one person, but--so along with that discussion

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then, it also allows the facilitation of what would be the--is one option better than another. In fact, some of the discussion that we had at that time was, you know, would it be enough to do public announcements and so on, or should there be specific steps taken to communicate with people, you know, in the different batches, or should they be tailor made to the individual reviewing their own situation and specific that way. Because as we were having the discussion, I remember it did come up that, you know, the doing of those things is very labour intensive, so that had to be considered as well, but with all that said and done, the ethics considerations regardless of--and resources are a consideration in the ethics options and so on, but with all that said and done, it was felt there should be a tailor made response or a communication with each person.
COFFEY, Q.C.:
Q. So if I could then on that point because I-- the Commissioner was--when I read this, I was somewhat puzzled about what ethically were the concerns here. I take it no one was taking

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any issue ever with the idea of not doing any harm or doing as little harm as possible, and correspondingly to try to do good.
MR. SINGLETON:
A. Uh-hm.
COFFEY, Q.C.:
Q. There was no issue taken with any of that.
MR. SINGLETON:
A. Uh-hm.
COFFEY, Q.C.:
Q. So here then, I take it, that Mr. Singleton, when you arrived at the meeting, really there were choice laid out which would be to do nothing further, that would be one choice, I take it, one option?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Another would be to kind of make a--run a blanket public advertisement campaign.
MR. SINGLETON:
A. Uh-hm.
COFFEY, Q.C.:
Q. Another might be to send a form letter to everyone who was retested, a particular style

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of form letter?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. And another option might be to send a letter to everyone who was retested, but particularized personalized--other than with your name, personalized to the patient's situation.
MR. SINGLETON:
A. Uh-hm.
COFFEY, Q.C.:
Q. Option.
MR. SINGLETON:
A. That's --
COFFEY, Q.C.:
Q. In terms of what you just outlined for the Commissioner for the kind of various possibilities.
MR. SINGLETON:
A. Yeah.
COFFEY, Q.C.:
Q. Were there any others, do you know?
MR. SINGLETON:
A. No, I don't, you know, I --

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COFFEY, Q.C.:
Q. That's the kind of ones that were on the table, as it were?
MR. SINGLETON:
A. That's right.
COFFEY, Q.C.:
Q. Then in terms of why an ethicist's views might be sought in that regard, are you telling the Commissioner that, look, each of those options has potentially different ramifications, they might do more or less good, depending upon one's view of good.
MR. SINGLETON:
A. Uh-hm.
COFFEY, Q.C.:
Q. As well, each of them have potential cost associated, or no cost associated with it, financial or otherwise.
MR. SINGLETON:
A. Uh-hm.
COFFEY, Q.C.:
Q. That's the thing you just referred to the Commissioner?
MR. SINGLETON:
A. Yes, those are some of the factors.

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COFFEY, Q.C.:
Q. That's one of the factors?
MR. SINGLETON:
A. Yeah.
COFFEY, Q.C.:
Q. So in term of then weighing it all then, this memo recorded at the time your view that the group's consensus was signed off on by the ethicist that the most expensive time consuming option in the sense of --
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. A message to each patient individualized to that patient's circumstances --
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Is the one to be followed here in weighing it all?
MR. SINGLETON:
A. That was felt to be the most complete, the most appropriate way to forge ahead.
COFFEY, Q.C.:
Q. And despite what might be the cost to manpower and money?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Doing it.
MR. SINGLETON:
A. The effort.
COFFEY, Q.C.:
Q. It would be worthwhile to go the full distance?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. And that's--have I captured that fairly, do you think?
MR. SINGLETON:
A. Very well.
COFFEY, Q.C.:
Q. Okay. So in terms of then kind of why they would ask yourself and--you to arrange it and Ms. Flynn and Mr. Pullman to show up and others to provide input, was a range of options possible from an ethics perspective, which would an ethicist recommend of those options?

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MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Have you received any feedback as to which option was actually followed?
MR. SINGLETON:
A. No, I--you know, once we completed that --
COFFEY, Q.C.:
Q. You did yours.
MR. SINGLETON:
A. (Unintelligible).
COFFEY, Q.C.:
Q. Then you sent around -
MR. SINGLETON:
A. Uh-hm, yes.
COFFEY, Q.C.:
Q. And you haven't heard about it since?
MR. SINGLETON:
A. That's right.
COFFEY, Q.C.:
Q. Mr. Singleton --
MR. SINGLETON:
A. I can't say I haven't heard about it because I know that--that because of another role that I had within Eastern Health, I was contacted to

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suggest some options in terms of having translations of letters done to other people related to this, but that was just kind of an indication to me that there was--that it was being followed up on.

COFFEY, Q.C.:

Q. And in relation to that then, you communicated with Ms. Pilgrim. Presumably, Ms. Pilgrim would be the one to take this up with?

MR. SINGLETON:

A. Yes, yeah.

COFFEY, Q.C.:

Q. In terms of this, just looking at the actual document itself, page one, the second last paragraph, you've got patients broken down into categories; with no change; tested with a change in ER/PR value, no change in treatment; patients tested with changes in ER/PR value and change in treatment; and patients retested who ought not to have been retested. Who are they, patients retested who ought not to have been rested? What category would that be, do you know?

MR. SINGLETON:

A. Well, my understanding is that in the process

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of sending samples for testing, that there may have been samples that were sent that weren't within the parameters that was sorted to be sent for testing. It's not a technical area that I have any expertise in, nor is the lab or lab operations anything that I've ever had any experience in, but that was my understanding of it that there were people who were making contact or who there was information about and they had to be followed up on.

COFFEY, Q.C.:

Q. Who actually had their tissue samples retested, but bearing in mind the original approach to this, they wouldn't have fallen into the category of people who were planned to be retested?

MR. SINGLETON:

A. That's my understanding, yes.

COFFEY, Q.C.:

Q. So even for them, if you were retested, the view of the group was send a letter to them too?

MR. SINGLETON:

A. That's right, yeah.

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COFFEY, Q.C.:

Q. Mr. Singleton, one final question on this matter, which is this wasn't mentioned when you were here in June, 2008, when you testified, I mean, this whole event in April?

MR. SINGLETON:

A. No, no.

COFFEY, Q.C.:

Q. Can you tell the Commissioner why not?

MR. SINGLETON:

A. We were discussing the case that we had in June. I think that's as much as we discussed.

COFFEY, Q.C.:

Q. And just because it just didn't occur to you to mention it at the time?

MR. SINGLETON:

A. That's right, I guess--well, I guess when I submitted material for the inquiry, it was prior to this.

COFFEY, Q.C.:

Q. Yes, and it was.

MR. SINGLETON:

A. And then--in your preparation for it, you didn't have it, and that was the focus of the discussion, and I think we were lucky to cover

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off all that you brought forward at the time without me needing to extend it further.

COFFEY, Q.C.:

Q. They are the questions I have, Commissioner. Thank you, Mr. Singleton.

THE COMMISSIONER:

Q. Mr. Pritchard.

MR. PRITCHARD:

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

THE COMMISSIONER:

Q. Mr. Browne.

MR. BROWNE:

Q. No questions for this witness. Thank you, Mr. Singleton.

THE COMMISSIONER:

Q. Mr. Pritchett.

MR. PRITCHETT:

Q. No questions, Commissioner.

THE COMMISSIONER:

Q. Ms. Newbury.

MR. RICK SINGLETON - EXAMINATION BY MS. JENNIFER NEWBURY

MS. NEWBURY:

Q. Good morning, Mr. Singleton.

MR. SINGLETON:

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A. Good morning.
MS. NEWBURY:
Q. My name is Jennifer Newbury, and I represent the Canadian Cancer Society, and I wanted to ask you about some comments that you made about having the right mix of people, and perhaps we could bring up Exhibit 0779, please, and this is having the right mix of people for the ethics consultation.
MR. SINGLETON:
A. Yes.
MS. NEWBURY:
Q. And I note that this document--this is an e-mail here, and you note that same phrase somewhere here. It's where the cursor is, "When organizing an ethics consult, we need to get the right mix of people to have a discussion and generate reasonable recommendations", and that concept, I guess, is covered in the ethics consultation pamphlet at P-1719. This is the Ethics Consultation Service pamphlet prepared in November, 2002, for the Health Care Corporation of St. John's, and I note over here on the right hand side, "The ethics consultation will provide an

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opportunity to discuss the issue concerned with a group who will bring a variety of viewpoints and opinions that may assist with your decision making. The committee's purpose is to assist you in your decision making, and not to make a decision for you". So I assume that's the same concept of getting the right mix of people?
MR. SINGLETON:
A. Yes.
MS. NEWBURY:
Q. And last time that you were here in June and testified, you indicated that your only experience was a group type consultation or a consultation involving more than one individual case related to a genetics issue, and at that time you indicated, I believe, that the individual's decisions about what would be done with their information differed from what the professionals felt the standard of practise would be, and that's what led to the genetics ethics consultation. I'm not sure if you recall that that was the evidence that you gave back in June. I think the point that you're making is that there were a group

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of people and there was, I guess, a dilemma there because the individuals had thought something would be done with their information, you didn't elaborate much obviously because of privacy reasons, but you indicated the individual's decisions about what would be done differed from what the professionals felt the standard of practise would be, and that led to the ethics consultation, and would you agree based on the concept of having the right mix of people, as well as your experience with having the other group, genetics type consultation, would those suggest that there would be value in having the patient's perspective or the patient's family perspective for an ethics consultation of the type that you engaged in in June of 2006?
MR. SINGLETON:
A. The ethics consultations that we have, the right mix of people really is matched with where it is in the process of moving forward with matters. There are ethics consultations --sometimes we have an ethics consultation that may go on for numerous meetings because

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of the complexities and all that happens. It's not uncommon that we would begin with a consultation that would include a small group, maybe just the care team, the ethicist, and facilitator. It may require a second session where there's others brought in because the scope of the discussion shows that, you know, it has complications that we need further resource people to assist with and so on. There are cases that--right from the start there are cases that it's the patient or representative of the patient who makes the request and they're part of the ethics consult right from the start. So the way it's done really is to match the--where the issue is as part of planning or part of offering options to the patient, or the family, or whomever, you know, or is it a broader operational type issue that is being sorted out where it's internal to the organization to look at what policies or procedures or options need to be considered before we go forward to enact an approach on it. So the right mix of people is contingent on, you know, at what phase this is and why it's being brought about, and what

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have you, and whether it includes people outside of our organization, managers, or frontline staff, or lawyers, or others, is all part of the consideration there.

MS. NEWBURY:

Q. And I understand that it can vary from circumstance to circumstance, but in this case here, given your only other experience in a large group consultation --

MR. SINGLETON:

A. Uh-hm.

MS. NEWBURY:

Q. Which seemed to suggest that there might be differing opinions between the patient's perspective and the organization's perspective, that there would be some value in having the patient's family's perspective for your ethics consultation in this particular circumstance. Perhaps it may not be necessary for some other reason, or there might be some other impediment there, but would you say that there is a value in having a patient's family's perspective?

MR. SINGLETON:

A. I think that when you're dealing with cases

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that involve more than one, or several, and where there's a fairly wide range involved, a wide range of patients with not altogether the same, but not altogether circumstances either, and where you're dealing with--say, you have, you know, a number of patients and a number of attending physicians, and what have you, I think that it is important that the ethics consult hold to a level where you're looking at it from the organizational level in terms of policies or guidelines and approaches and so on that will be taken that can be tapered to and tailored by individual situations to the extent that it can be managed that way. I suppose that is an issue and a challenge around the whole business of disclosure, that so much of the directions that health care organizations have had, and ethics discussions and so on are in a similar boat, to some extent, that when--there's so much of the approach is focused on, presumes an individual patient, and individual attending physician, and specific team members, and so on. When you get into this broader organization type of systemic types of challenges, some of the--

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there is a case, quite rightly so, that individual patients would like to have a say about their own matters, and which options they would like to choose from, but to lay out what the options might be is part of--you know, has to be part of an organizational plan. So I think there's tweaking that needs to be done around that kind of stuff for these types of situations.

MS. NEWBURY:

Q. I guess I'm still not quite understanding what your view is in terms of whether or not there would be value in having a patient's family perspective, and perhaps I can ask it this way, did you feel that there was a problem in getting that perspective because of the large numbers involved?

MR. SINGLETON:

A. No, I think--I'm sure that we could have gone to a variety of sources to get family and patient perspectives. Whether or not those family and patient perspectives would represent all families and patient perspectives would be--you know, is always a consideration when you're doing consultations

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in the community on any matter, or stakeholders, then how do you sort out when some represents everyone. It's always an issue in research ethics and it's an issue in clinical ethics as well, but--so it isn't because there wouldn't be people available. The reason why we had the right mix that we had was because it was at that time essentially an internal matter that we were looking at to give assistance in a decision that had to be made within the lab. You're talking about the 2006 occasion?

MS. NEWBURY:

Q. Yes.

MR. SINGLETON:

A. That they had reports there that needed to be signed off, as Dr. Cook called it, and it was to assist in the considerations of what implications that will have as we move forward.

MS. NEWBURY:

Q. Okay, and in your view, it wasn't necessary then or wouldn't have been valuable to ascertain what the patients or the families of the deceased patients would have wanted to do

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in those circumstances? I mean, those records that existed at that point in time related to families of a deceased patient that actually existed. I mean, these were identifiable individuals, so whatever decision was made would impact upon those particular people. It's not coming up with a policy down the road for people who were not yet identified.

MR. SINGLETON:

A. Uh-hm.

MS. NEWBURY:

Q. And you didn't see it that time, and it seems that you don't see now that there would have been any value in having some perspective and perhaps representative of the Canadian Cancer Society or breast support group member, or someone of that sort, who might be able to put forward ideas of concerns from the other part of the picture?

MR. SINGLETON:

A. Yeah, I think that happened in 2006 with a scope of insight about what was happening at that time, and I don't feel that it's a fair question to ask me what I would have done with that case at that time. I think most people

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would probably analyze their approach to most of the matters around this stuff differently at this time than they did then.

MS. NEWBURY:

Q. Sure, and what would you do at this time?

MR. SINGLETON:

A. Well, at least considered it, you know.

MS. NEWBURY:

Q. Okay. Mr. Singleton, based on the conclusions or the repot of the ethics consultation, if Eastern Health after that consultation back in 2006 choose to directly contact patient's families to let them know that retesting had taken place and that results were available if they chose to obtain those results, or that retesting is available for those who had not yet had their specimens retested, would that be inconsistent or consistent with the conclusions in the ethics consultation?

MR. SINGLETON:

A. To contact the families of the deceased?

MS. NEWBURY:

Q. Yes. You had two groups, you had some who had already been retested.

MR. SINGLETON:

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A. Yes, right, yes.

MS. NEWBURY:

Q. And results would have been available.

MR. SINGLETON:

A. Uh-hm.

MS. NEWBURY:

Q. And then you had another group whose specimens were not yet retested, and perhaps I could bring up the ethics consultation for you to have a look at it. It's P-0783, please. It's on the next two pages if you wanted to scroll down and have a look at that just to refresh your memory.

MR. SINGLETON:

A. So your question?

MS. NEWBURY:

Q. If Eastern Health chose to directly contact patients' families to let them know that retesting had already taken place and results were available, if they chose to obtain those results, so they would still have a choice of no, I don't want them or yes, I do, or to advise the families or the next of kin of a patient that retesting is available if they -

MR. SINGLETON:

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A. Um-hm.

MS. NEWBURY:

Q. - so wanted to get that done, would that be consistent, would that be consistent or would it be inconsistent with the ethics consultation?

MR. SINGLETON:

A. Yes. Well, the recommendation from the ethics consultation was that it be made known through, you know, public relations we might say, public communications, means that the information either is available or will be made available for you and to allow people to follow up on it to the extent--to when and as they want, and some of the discussions we had around that, and we reviewed it when I was here earlier, so don't need to go into it, was about people needing or wanting to do this at a time that works well for themselves, considering if they're dealing for the most part with people who have had a recent significant loss. So that was what we were recommending, and you know, in part why we were recommending it. If an initiative was taken to make the contact, well, it would be

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following up on it and making it available. It wouldn't be the process that we had suggested to do for it, and it would be going forward to lay information on people who might not be ready or might not want it, and another consideration in it is whether or not the person being approached would be the one who ought to receive the information anyway. So there's that consideration as well when you're dealing with someone other than the patient themselves, because it's who is identified as next of kin or person to notify in case of emergency and so on is not always the person who should have access to the health information. That's a consideration as well.

So the recommendation was based on the obligation to lay it out there, to allow people the opportunity to respond when and as they wanted, somewhat related to what you were asking earlier on about people, you know, having their own perspective. Well, different families and what have you might go about doing it differently, and different members of different families might as well. So there's those matters that have to be sorted out one

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way or another.

MS. NEWBURY:

Q. But I guess, in terms of the mechanics, if Eastern Health, rather than doing a press release, which may not reach everyone who needs to know, some people may not understand enough or may be out of the province, for example, on holidays and miss the press and we've had examples, I think, in the Inquiry where people happened to be away temporarily and don't hear these types of announcements. Would a letter directly to the patients, not telling them directly what the results are, but just saying the results are available if you want and they can keep it for a year or come immediately or never come at all to get that.

MR. SINGLETON:

A. Yes.

MS. NEWBURY:

Q. But would that letter approach be consistent with what you've outlined in this?

MR. SINGLETON:

A. Well, it wouldn't be following what we recommended, but it wouldn't automatically be

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wrong and what have you. I mean, there might be a good reason why another approach might be seen to be, you know.

MS. NEWBURY:

Q. Was the letter approach contemplated at the time as a possible method of contacting the families of deceased patients?

MR. SINGLETON:

A. Yes, yeah.

MS. NEWBURY:

Q. It was?

MR. SINGLETON:

A. Yeah.

MS. NEWBURY:

Q. Okay, and it was ruled out. Was that because of resource issues within Eastern Health or was it because of the ethics?

MR. SINGLETON:

A. No, resources weren't part of that discussion at all really, I suppose, you know, in terms of the communication. It was essentially about the timing of it, when and how the approaches would be made and to whom to give the information and what have you, and that was really what the discussion was about at

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that time, to allow people to come forward and as I mentioned in June, a substantial amount of my work is in the area of grief counselling and often involved with people who've had tragedies of one sort or another and quite often, people share, you know, that they don't want the autopsy report. I've been involved with a fair number of situations where, within families, there's substantial dispute because, you know, one person is quite anxious to get a report of something and others aren't, and so there's a certain amount of, you know, internal matters in the family that have to be sorted out and those types of things. So that was part of the discussion there. There was no substantial discussion, if any, about it being a resource factor.

MS. NEWBURY:

Q. But sending out a press release and advising that results could be available for deceased patients, would that resolve issues about any disputes among family members or if it's, you know, a terribly bad time for the families to get that news?

MR. SINGLETON:

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A. At least it would give them, if they knew that--you know, if they wanted to move forward, at least it would give them opportunity to make some decisions and have some discussions amongst themselves rather than someone calling or sending or by whatever means the information being brought into the family when the timing isn't good for some or for all or what have you. So at least it would give them an opportunity to, you know, focus on some of their personal matters. I doubt there's any process that can--would work perfect for everyone, but generally speaking, if people know that there is something that might be available to them, at least amongst the people in the inner circle of the family that have a bit of a discussion amongst themselves and decide what way they might want to move forward with it.

MS. NEWBURY:

Q. I guess I'm not understanding why a letter advising families or the next of kin that results are available would be any different, other than providing certainty that they've actually obtained the information that the

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results are available. It's not imposing information upon those individuals. It's not telling them, "here are the retest results." It's just saying they are available, please contact us, you know, at any time that you feel you're ready for that information. I don't see how that would be any more problematic for families who need to discuss that than hearing it in the press release. Personally, I see that there would be an advantage because it provides some certainty that they would actually get the information rather than the press release, which may very well not reach the intended audience there. Is that something that you agree or disagree?

MR. SINGLETON:

A. It's your analysis of it.

MS. NEWBURY:

Q. Pardon?

MR. SINGLETON:

A. That's your analysis.

MS. NEWBURY:

Q. Yes, I'm just wondering if you agree. Is there anything that you can shed light on from the ethics consultation? Is there anything

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that--okay. Mr. Singleton, you'd mentioned that--in your evidence in June of--June 19th, I believe, that where there's an incident involving the death of one single patient and there's a clear identifiable mistake in that case that there would be an ethical obligation to advise the family members of that. I believe that was your evidence back in June.

MR. SINGLETON:

A. I think we were talking about the adverse events and the -

MS. NEWBURY:

Q. Yes, that's correct.

MR. SINGLETON:

A. - typical details and guidelines and what have you that are there to handle those situations.

MS. NEWBURY:

Q. Okay, and there would be an obligation to, I guess, a positive obligation to contact family members and to advise them of that information, I understand.

MR. SINGLETON:

A. Um-hm.

MS. NEWBURY:

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Q. Did you consider, at any point during the ethics consultation about how to handle the results for the deceased patients, whether there would be an ethical obligation for the organization to--being alerted to a potential problem, that there were some possible problems which led to the differing test results, to investigate or explore whether there could be an error connected with the death of the patient?

MR. SINGLETON:

A. No. Well, the discussion was focusing on the communication piece of it and it wasn't so much about the--you know, investigating what the--there was no--it obviously wasn't the role of an ethics consult to try and get to the root of where the problem or problems that led to it were and my understanding, as we discussed back in June, was that there was certainly broad, deep systemic matters that contributed to it and made it different in many regards from the individual type of situation that, I think, most of the guidelines in health care across Canada focus on situations where there's a cause and a

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patient and what have you, and you know, background you had to your question.

MS. NEWBURY:

Q. So does that mean then that any possibility that there had been errors leading to the death or in way connected with the death of the patient had been ruled out in your mind doing this ethics consultation?

MR. SINGLETON:

A. I think the--I don't think, I know. The understanding that I had of like the errors and what I was separating out in the particular case that we had in June was that the situation was different, by my understanding, than if there had been a situation of an overdose that was given of some medication and those kinds of things, and that type of specific error, you know, by a specific individual and you know, all the details are present for it. That was quite different than what we were dealing with here, and certainly, you know, what I understood to be the situation from the way that we had a bit of discussion on it and in the front end of that ethics consultation is that there were

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a variety of problems that contributed one to the other and brought about the eventuality of all the PR/ER complications and what have you. But we didn't have a lot of discussion about--or any discussion about specific mistakes and that kind of stuff, and in fact, that's why I phrased it as I did, that you know, there were no specific mistakes or individuals or whatever way it was said in that same text as you have on the screen there. But that's what I was thinking of, you know, the specific type of situation as different than the more systemic problems that I understood it to be.

MS. NEWBURY:

Q. Just generally speaking, if you have a somewhat unexplained death and you also had some possible problems involving the patient's care, is it only when it's plain and obvious that there was a mistake that you would then take steps to communicate to the patient or would there be some obligation, from an ethical standpoint, to delve into that a bit further, to find out if there was a possible mistake connected to the death of the patient?

MR. SINGLETON:

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A. I think in the guidelines around individual cases, what typically happens, and I don't remember all the details of how they're articulated now, but I mean, whatever information that you know would be presented and then, you know, whatever would be sought to try and give further explanation on it would be part of what would be pursued.

MS. NEWBURY:

Q. Okay.

MR. SINGLETON:

A. With the patient or whomever, family I should say.

MS. NEWBURY:

Q. And the decision to communicate with the patient, based on a single patient and the death of a single patient, the decision what to communicate to the patient is important to know whether or not there is a mistake or technical error, I believe. If there is one, then that has to be explained to the patient and is it any less important to do that if there's a group of individuals involved to find out if there's a mistake that led to the death of the patient and to then make your

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decisions about communication based on what is found?

MR. SINGLETON:

A. I think, you know, generally there'd be a desire to get to the root of the problem and correct it and deal with whatever the outcomes are for whomever, families included but also others who may have the same types of conditions to prevent the same unfortunate eventualities.

MS. NEWBURY:

Q. Okay. Thank you, Mr. Singleton. Those are all the questions.

THE COMMISSIONER:

Q. Thank you. Mr. Crosbie?

MR. RICHARD SINGLETON, EXAMINATION BY CHESLEY CROSBIE, Q.C.

CROSBIE, Q.C.:

Q. Good morning, Mr. Singleton.

MR. SINGLETON:

A. Good morning, Mr. Crosbie.

CROSBIE, Q.C.:

Q. Could we, Registrar, could we have Exhibit 1690 brought up please? I asked Mr. Simmons if he could kindly request of you that you

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have a look at this last night and bring your mind back to when this may have occurred or what it represents. Did you have a chance to do that?

MR. SINGLETON:

A. Yeah.

CROSBIE, Q.C.:

Q. So what is it we're looking at, sir?

MR. SINGLETON:

A. We're looking at a calendar page, September 2006, and it's--I don't see there whose page it--it's Susan Bonnell.

CROSBIE, Q.C.:

Q. Do you understand then that this is Ms. Bonnell's own calendar?

MR. SINGLETON:

A. I presume it is.

CROSBIE, Q.C.:

Q. Her name at least appears in the lower left-hand corner.

MR. SINGLETON:

A. Yeah.

CROSBIE, Q.C.:

Q. There's a date on the lower right in 2008. I'm guessing myself that that might be the

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date it was printed off, but -

MR. SINGLETON:

A. I expect, yes.

CROSBIE, Q.C.:

Q. Right in the middle of that, everything else is blocked out, all the names and identifiers, but there's an entry for 10:30 on that Wednesday, the 13th of September, 2006. It says "I-N-V-U, Rick Singleton, Rick's office." What does "I-N-V-U" mean, sir, do you know?

MR. SINGLETON:

A. Not sure. Oh yes, I do, yeah, I know what it means. Interview, I expect.

CROSBIE, Q.C.:

Q. And so it appears that Ms. Bonnell was visiting you at your office to interview you?

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. Do you recall the exchange?

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. And what can you tell us about it?

MR. SINGLETON:

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A. She was doing an article for a publication that Eastern Health has. I think it's called The Loop or Our Health or something like that. And she was doing an interview with me about working with--things that people can do to help each other and help themselves in dealing with loss. So she was--that was one of the sections in the magazine that she was producer or editor of that, you know, there were different sections and interviews with people on things that would be seen to be of benefit to the readers and in the community.

CROSBIE, Q.C.:

Q. And you have experience in grief counselling, you told us last time you were here in June.

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. But the discussions had nothing to do with the ER/PR controversy? Is that the case?

MR. SINGLETON:

A. That's right.

CROSBIE, Q.C.:

Q. Well, thank you for that. I was curious about that when I saw Ms. Bonnell interviewing you,

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but you've clarified that for us. Sir, you told the Commissioner last time, in June, June 19th when you were here, that you were involved with the development of disclosure policies throughout the life of the Health Care Corporation? I can see the nod -

MR. SINGLETON:

A. Yes, yes.

CROSBIE, Q.C.:

Q. - but the transcript can't.

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. Can we go to document 0056, page 18, please? That's entitled Administrative Policy Manual.

REGISTRAR:

Q. Page 15, was it?

THE COMMISSIONER:

Q. 18, you asked for?

CROSBIE, Q.C.:

Q. 18 I asked for. The section is Legal Ethics, the title, Guidelines on Disclosure of Adverse Events. Issuing authority, VP Medical Services. Do you recognize the signature?

MR. SINGLETON:

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A. By VP, I presume it is Bob Williams, Robert Williams. I'm not sure.
CROSBIE, Q.C.:
Q. You're not sure if you recognize that signature?
MR. SINGLETON:
A. No.
CROSBIE, Q.C.:
Q. There is also handwriting, August 1st, 2005. Is that the date it came into effect, do you think?
MR. SINGLETON:
A. I expect, yes.
CROSBIE, Q.C.:
Q. Or is it -
MR. SINGLETON:
A. At least the date it was signed.
CROSBIE, Q.C.:
Q. Or was it in effect on the 9th of September 2004?
MR. SINGLETON:
A. By the format of the policy, it would have been in effect in 2004.
CROSBIE, Q.C.:
Q. In any event, it was in effect as of the date

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of your consult that we delved into in considerable detail on June 19th?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. Would you explain to us how a document like this is developed?
MR. SINGLETON:
A. Well, there's a lot of work on that type of a document because it's an administrative policy. But I was involved with doing some of the ethics work on it and we had a working group that I was chair of for that piece of it, and then when we would complete our piece of work from the ethics end of it and some of the principles and what have you that needed to be part of the policy and integrated into it, we'd bring it forward to the VP that I reported to at the time, Louise Jones, and she would be the person who'd bring it on forward at the executive level to make sure that there was, you know, other broad based consultation and input.
CROSBIE, Q.C.:
Q. So there's a committee for this specific

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portion of the policy manual?
MR. SINGLETON:
A. We had, within the ethics activities, we had a particular working group on disclosure of adverse events and a substantial amount of material in it, we would have our own discussions would be integrated into it. We'd review the various drafts and so on, until we had completed what we felt we would have input on, and then it would, through the executive level, get the approvals and the refinements that might be needed to bring it into the policy manual.
CROSBIE, Q.C.:
Q. Can you tell us who's involved in that working group, very quickly?
MR. SINGLETON:
A. I can't tell you right off the bat, because I don't have it in--I don't have the notes and those kinds of things from me, but we would have had at least one ethicist involved in it, as well as myself and trying to remember--would have had a sample of representatives from the ethics committees, and so they're kind of multi-disciplinary, so without

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remembering exactly who was on that particular working group, because we have many of them on different types of projects and policies and what have you, but there would have certainly been nursing and front line and management people and so on involved, don't remember exactly though who was involved in -
CROSBIE, Q.C.:
Q. Physician input?
MR. SINGLETON:
A. Well, physician input in this type of a document would have largely been through MAC and that level.
CROSBIE, Q.C.:
Q. So this document was sent to MAC for their -
MR. SINGLETON:
A. I mean, it's typically how those things go, and I'd be pretty sure that the VP for Medical Services wouldn't sign the document on adverse events without it having been approved by MAC.
CROSBIE, Q.C.:
Q. So all of the stakeholder groups in your organization, up to and including MAC and, as we see, the Vice President Medical Services, were consulted and approved of the contents of

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the document? We can say that, can we?
MR. SINGLETON:
A. I think so, yes.
CROSBIE, Q.C.:
Q. They all knew about it?
MR. SINGLETON:
A. They all had opportunity to know about it would be one thing that I could say with confidence. Those things are distributed for people to provide feedback and what have you, and they do it to the extent that they want to.
CROSBIE, Q.C.:
Q. You believe that what's contained in that policy we're looking at right there is ethical, sir?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. It's a good set of principles and guidelines to follow?
MR. SINGLETON:
A. I think it is. The mind set around it at the time was the typical pattern that those things have had up to--really up to now or up to

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quite recently where the focus is on, as I mentioned earlier, on individual cases and situations and what have you, but for that purpose, that is what it was intended to do and I think it's a good set of guidelines, yes.
CROSBIE, Q.C.:
Q. Well, the purpose is to give guidelines on disclosure of adverse events, right?
MR. SINGLETON:
A. Um-hm.
CROSBIE, Q.C.:
Q. So it's a good set of guidelines for that purpose?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. Incidently, are these manual items, including this, available to the public by way of being posted on the institution's website?
MR. SINGLETON:
A. I'm not sure if they are now or if they were in the past. I'm not--I don't know.
CROSBIE, Q.C.:
Q. I suggest they aren't. If that's the case, do

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you think they should be?
MR. SINGLETON:
A. I wouldn't see any reason why people couldn't or shouldn't know that. Whether it would be made known to people by posting of the material on the website or by other means or what have you, I suppose there are a variety of ways that that type of information can be made known to people.
CROSBIE, Q.C.:
Q. Well, posting things on websites nowadays -
MR. SINGLETON:
A. Is one way -
CROSBIE, Q.C.:
Q. - is a pretty standard means, isn't it?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. You don't see any objection to that, do you?
MR. SINGLETON:
A. I don't, you know, from my perspective, but I've never really thought about it up to this point.
CROSBIE, Q.C.:
Q. Well, the more knowledge there is of

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guidelines such as those on disclosure of adverse events, the better, isn't that so?
MR. SINGLETON:
A. I would think so, yes.
CROSBIE, Q.C.:
Q. Would that be--then the posting of this on the website, would that be a recommendation that you would support?
MR. SINGLETON:
A. Just, you know, off the--without having thought about any other consideration only the bit of discussion we've had on it here, I would say yes, that would be something I'd support.
CROSBIE, Q.C.:
Q. Well, the Commissioner has to make recommendations later on, so if it occurs to you--I know this is something that may be new, so if it occurs to you there are reasons why that should not be done, perhaps it's reasonable to ask you, by the end of the week, to let your counsel know. It could be done in writing, and we can deal with it on that basis. There may be things you haven't thought of that you'd like to bring to the

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Commissioner's attention. Does that seem reasonable?
MR. SINGLETON:
A. Sure, thank you.
CROSBIE, Q.C.:
Q. Thank you. Sir, Dr. Cook's issue was whether he had to disclose anything to the families of the deceased patients.
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. It was important to the -
MR. SINGLETON:
A. Well, actually, the consult that we had was that he had reports that needed to be signed off. The discussion, the further discussion that we--when we got into the discussion about that, the issue of disclosure became part of it. But the ethics consult was about what does he do with the reports that he had.
CROSBIE, Q.C.:
Q. Well, yes, when they're signed off, then what.
MR. SINGLETON:
A. Well, it was -
CROSBIE, Q.C.:

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Q. That was the issue?
MR. SINGLETON:
A. That was the issue.
CROSBIE, Q.C.:
Q. So the issue really was whether there had to be disclosure of anything to the families of deceased patients?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. It was important to the ethics opinion to know that there were no mistakes or technical errors at the root of the problem.
THE COMMISSIONER:
Q. Is that a "was it important" or -
CROSBIE, Q.C.:
Q. I'm making that as a statement, but everything I say, sir, you can consider to be a question. You can say yes, you can say no, you can qualify it. However, that statement appears in your consult, so I assume it's true.
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. So you agree?

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MR. SINGLETON:
A. That was what I wrote in the consult, yes, or in the summary.
CROSBIE, Q.C.:
Q. And you stand by that now or not?
MR. SINGLETON:
A. I wouldn't write it that way now. It was my understanding of it at that time, with the mind set that I had or what I was thinking of in light of how we approach issues of disclosure of adverse events and so on, thinking of there being a specific individual or a specific piece of equipment or something that was quite -
CROSBIE, Q.C.:
Q. Yes, but what you have reservations about now is whether there were mistakes. Is that the idea?
MR. SINGLETON:
A. Well, yes, there has been lots of information through the process of this Inquiry that certainly brings forward that there were--that there are reports that identify mistakes and comment on mistakes.
CROSBIE, Q.C.:

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Q. Okay. So setting aside the question of whether there were actual mistakes, it remains important to an ethics consult to know if there were mistakes?
MR. SINGLETON:
A. Yes. Yes, I think to a great extent, depending on what the focus of the actual discussion is, but it would be important to have as much information as possible.
CROSBIE, Q.C.:
Q. That's because the obligation to inform is different where a mistake has been made?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. You were advised that there were no mistakes or technical errors at the root of the problem?
MR. SINGLETON:
A. It was my understanding at least of the discussion, in the discussion from when we settled into getting the background on it. That was my understanding from the comments that were being made and the way things were being described is I was understanding that

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there was a lot of complex systemic issues and problems that had come together and caused this situation to come about, and what I was intending, as I've said several times before, by the description of mistake is that there was a specific perhaps repeated error by a specific individual who could be identified or a specific calibration of a piece of equipment or what have you.

CROSBIE, Q.C.:

Q. Sir, are you bringing in the concept of someone being to blame or at fault now?

MR. SINGLETON:

A. I suppose that would be along the lines of what I was thinking of, not necessarily someone, but at least that there would be something identifiable as the specific cause or causes of the problem.

CROSBIE, Q.C.:

Q. Is that because the concept of avoidability is important?

MR. SINGLETON:

A. Avoidability, not sure. Could you -

CROSBIE, Q.C.:

Q. Whether an adverse event is avoidable or not

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avoidable.

MR. SINGLETON:

A. Oh yes, well -

CROSBIE, Q.C.:

Q. You testified to that.

MR. SINGLETON:

A. Yes, that's right, and it wasn't -

CROSBIE, Q.C.:

Q. And we made notes on that.

MR. SINGLETON:

A. - it wasn't about the ethics of it, no. I don't think that the blame or the culpability piece, as you mentioned a moment ago, would be so much a part of what I was talking about as to whether or not it was avoidable or unavoidable.

CROSBIE, Q.C.:

Q. So that's an important concept in an ethics consult, avoidability?

MR. SINGLETON:

A. No. Well, it may be, depending on what you're--what we're talking about. It may be important and it may not be.

CROSBIE, Q.C.:

Q. Well then, why was it important to the ethics

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opinion to know that there were no mistakes or technical errors?

MR. SINGLETON:

A. Well, I think it was in terms of lining it up with what we had laid out as means to deal with adverse events as you know, by the guidelines, that you know, that was kind of what I was trying to put into a summary after we had the consult and give some background to it. I think that the piece that we wanted to push, that we were into more substantially in the discussion was about the process to disclose to patients or to families.

CROSBIE, Q.C.:

Q. All right, sir, I'll leave it to others to judge whether you've actually answered the question, but I want to come back to something that I do want to ask you. The idea that you got that there were no mistakes or technical errors at the root of the problem, this advice came partly from the report that Dr. Denic started to read?

MR. SINGLETON:

A. No, I don't think that--Dr. Denic didn't read much of his report, if he read any. He took

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it out and I think--I'm not sure if he read anything from it. I don't remember anything specific, but as soon as he made mention of it, probably took a paper from somewhere or other, then Dan Boone raised issue with it and eventually it was set aside. I'm not sure what was in that report.

CROSBIE, Q.C.:

Q. Did you get the impression the report supported the idea that there were no mistakes?

MR. SIMMONS:

Q. Excuse me, Commissioner. (inaudible) of exploring the content of the report. We've already had that issue come up earlier and (inaudible) when Mr. Coffey was asking.

CROSBIE, Q.C.:

Q. I'll drop the report at this point.

THE COMMISSIONER:

Q. All right, thank you.

CROSBIE, Q.C.:

Q. Like to switch to something slightly different, sir. The response your consult recommended was to communicate through a press release?

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MR. SINGLETON:
A. Yes, yes, or I'm not sure if it was specifically a press release, but that it be part of the overall, you know, communications through the media at least.
CROSBIE, Q.C.:
Q. Media communications and a press release is specifically mentioned.
MR. SINGLETON:
A. Okay, yes.
CROSBIE, Q.C.:
Q. So you're going to--the proposal was to communicate with the families of the deceased through a press release and perhaps in other ways through the media?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. The families would be required to make requests for information in writing?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. Contact would be managed by the risk manager?
MR. SINGLETON:

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A. Yes.
CROSBIE, Q.C.:
Q. The risk manager's job was to contain risk?
MR. SINGLETON:
A. Yes, well, that's the role or one of the roles at least.
CROSBIE, Q.C.:
Q. You could have recommended communication with the families directly?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. This would better ensure actual notice of their rights than communication through a press release?
MR. SINGLETON:
A. If the communication was to the right person in the family, person with the--who was entitled to the information, and if that information was in fact available.
CROSBIE, Q.C.:
Q. But you chose a press release?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:

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Q. Which would ensure, sir, less actual notice to families of deceased patients took place.
MR. SINGLETON:
A. I'm sorry, I didn't hear what -
CROSBIE, Q.C.:
Q. It would ensure that less actual notice to the families took place.
MR. SINGLETON:
A. It may.
CROSBIE, Q.C.:
Q. And as we've seen from the document that was just introduced today, probably more confusion and uncertainty amongst the families.
MR. SINGLETON:
A. But I'm not sure if the confusion and uncertainty was from families who had had someone die or if they were from patients who had had the diagnosis and were part of the testing or what have you.
CROSBIE, Q.C.:
Q. We've just seen a situation where an ethics consult had to address a situation where there is no written communication, but oral, and this resulted in confusion.
MR. SINGLETON:

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A. Yes.
CROSBIE, Q.C.:
Q. And your solution was to send letters?
MR. SINGLETON:
A. Yes, to the people who had been retested and -
CROSBIE, Q.C.:
Q. And you could have done that several years ago, in 2006, couldn't you?
MR. SINGLETON:
A. Could have, yes.
CROSBIE, Q.C.:
Q. Sir, specific recommendations from an ethics consult, you told us in June, are added to the health record in individual cases.
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. That's the policy?
MR. SINGLETON:
A. Yes, that's what we typically do with--if the ethics consult is going to have an impact on the care plan.
CROSBIE, Q.C.:
Q. But you don't follow that approach in batch cases?

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MR. SINGLETON:
A. No, and we haven't had many batch cases, but we wouldn't be because in some of those types of things they're non-specific, but in this type of case, people could be identified.
CROSBIE, Q.C.:
Q. I'm not sure I follow.
MR. SINGLETON:
A. Okay. In individual cases, they are about the particular matters. People are identified and the options that are being considered and so on, and so a notation is made in the health record if it is going to impact on the care plan, if issues have been raised where there's a dispute about what options should be considered or should not be considered and what have you. There are time that there are ethics consults where there isn't a notation because it's before there's ever a care plan set up or the matters that are being discussed are irrelevant to the care plan. But generally speaking, when the discussion matters to the care plan, then there's a notation made in the health record.
CROSBIE, Q.C.:

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Q. Well, sir, you come back to care plan, but in deceased cases, how does care plan come into it?
MR. SINGLETON:
A. In what cases?
CROSBIE, Q.C.:
Q. Deceased.
MR. SINGLETON:
A. Yes, well, there isn't a care plan.
CROSBIE, Q.C.:
Q. So then does that mean that you never enter the ethics consult in the chart of a deceased patient?
MR. SINGLETON:
A. That's right.
CROSBIE, Q.C.:
Q. Oh, so that's a qualification on what you do with ethics consults? They aren't necessarily added to the health record in individual cases at all, at least not in death cases?
MR. SINGLETON:
A. That's true. In this very different type of consult, it certainly wasn't.
CROSBIE, Q.C.:
Q. But not in any death case? That's what you're

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telling me now, is it?
MR. SINGLETON:
A. We typically don't have these types of cases. We've had cases where the consult that we've had is about a person who is at end of life and the notations will be in that person's health record and sometimes the person has died before the summary is completed and it would be entered into the health record then.
CROSBIE, Q.C.:
Q. Sir, are you telling me that you don't document a health consult in the charts of deceased patients as a matter of policy, no matter what other circumstance is obtained or are you telling me that you waive the normal policy in favour of documenting the consult in the chart in this particular case?
MR. SINGLETON:
A. But in this particular case of the--you mean the consult we had in June 2006?
CROSBIE, Q.C.:
Q. Yes.
MR. SINGLETON:
A. You could say we waived the policy, if you want to describe it that way. The case was so

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different than any other cases that we've ever had that, you know, I for one, and I doubt anyone else was kind of thinking of it in the same format or follow up as we would do in cases that were specific to an individual.
CROSBIE, Q.C.:
Q. To your knowledge, was any occurrence report placed on the deceased patients' charts?
MR. SINGLETON:
A. I have no knowledge of that.
CROSBIE, Q.C.:
Q. So I take it, in giving this consult, you obviously considered the ethical legal guidelines on disclosure of adverse events that we see in front of us here? That's a yes?
MR. SINGLETON:
A. I was familiar with them anyway, yes.
CROSBIE, Q.C.:
Q. And you would have been duty bound to apply that?
MR. SINGLETON:
A. You could say that, yes. Well, as an organization, we have them. So it wouldn't be only me. As an organization, we'd make

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efforts to apply those types of policies where we're aware that they apply.

CROSBIE, Q.C.:

Q. Yes. Do you agree with my question then that you would be duty bound to apply these policies?

MR. SINGLETON:

A. To make the best effort we can, yes.

CROSBIE, Q.C.:

Q. Just best efforts?

MR. SINGLETON:

A. I think the--in this, in the case that we're talking about, the ER/PR situation, from my familiarity with the adverse events guidelines and framework, most of the thinking was specific to--it was related to specific types of cases. I think the overall understanding of the ER/PR situation was more--it had many--much less specific information than I was familiar with regarding disclosure of adverse events.

CROSBIE, Q.C.:

Q. So you might have to adapt the policy guidelines to fit circumstances which weren't necessarily in contemplation when they were

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drafted? Is that what you are saying?

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. Now did this ethics consult involve an adverse event?

MR. SINGLETON:

A. Definitely, yes.

CROSBIE, Q.C.:

Q. It involved an adverse event or occurrence, as defined in policies, right?

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. Because it's defined pretty broadly.

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

Q. I'm just going to bring this down, if my mouse works, under procedure. It says, under item two, "initiate an occurrence report" and you say you don't know whether that was done?

MR. SINGLETON:

A. I don't know.

CROSBIE, Q.C.:

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Q. So, therefore, you would not have seen any occurrence report that was done in the course of this consult?

MR. SINGLETON:

A. No, that's right.

CROSBIE, Q.C.:

Q. Did you ask whether there was such a document?

MR. SINGLETON:

A. No.

CROSBIE, Q.C.:

Q. Do you think you should see that document in the process of an ethics consult where there's been an adverse event or occurrence? Should you see it?

MR. SINGLETON:

A. It could be a helpful piece of information, yes.

CROSBIE, Q.C.:

Q. As a general rule, should you see that document?

MR. SINGLETON:

A. Yes, if it was a case coming forward as a typical adverse event, I'd suspect we'd go looking for it. In this case, it was so different, I would have to say that we

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wouldn't have approached it similar to other types of situations that might come about.

CROSBIE, Q.C.:

Q. Well, what does an occurrence report typically tell you? Give you a background about what happened, I guess.

MR. SINGLETON:

A. Right, yes.

CROSBIE, Q.C.:

Q. Did you ask whether there is a background documentation setting out what happened?

MR. SINGLETON:

A. No, I didn't, no.

CROSBIE, Q.C.:

Q. And given that this involved many people, you felt that was not necessary, is that the idea?

MR. SINGLETON:

A. Well, I think it was because the people who were meeting to have the discussion would be able to provide background to the situation in the case.

CROSBIE, Q.C.:

Q. And did you rely on them to give you full and fair and accurate information about the background of the case?

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MR. SINGLETON:
A. To the extent that we needed it or, you know, that we pursued the background of it, the focus that we had essentially and what the consult was intended for was to address the issue of the reports pertaining to deceased patients, and that was the focus that we had in our--in setting up the consult and the people who were asked to be part of it were ones who were connected to the whole ER/PR undertaking, and Dr. Cook, of course, was the one who had written Dr. Williams about it. So that was the focus that we were taking in the ethics consult. It wasn't to analyze the adverse event, so to speak.
CROSBIE, Q.C.:
Q. You had no choice but to rely on the good faith of those individuals you named to tell you what you reasonably needed to know in order to discharge your ethics consult function?
MR. SINGLETON:
A. Uh-hm.
CROSBIE, Q.C.:
Q. You agree with that?

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MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. I'm just going to go over to page 19 of this. Can you read disclosure, the item disclosure, paragraph six under that title. Just read it to yourself is fine, and if you're satisfied, I'm going to ask you to read item--paragraph 7K, "Apologies are appropriate", do you see that there?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. And go back to disclosure. Do you consider that your consult conformed with that item, paragraph six, and with paragraph 7, under disclosure, which indicates there should be a meeting with the patient as soon as possible, in this case the patient's family, and that you should take the lead and that you don't wait for the patient to ask?
MR. SINGLETON:
A. Clearly it didn't match those guidelines.
CROSBIE, Q.C.:
Q. Your consult did not conform with that, did it?
MR. SINGLETON:
A. No.
CROSBIE, Q.C.:
Q. Did it conform with the stricture that apologies are appropriate?
MR. SINGLETON:
A. No.
CROSBIE, Q.C.:
Q. Under documentation of disclosure, sir, read item 8. Would you please read that aloud because I believe that's important.
MR. SINGLETON:
A. Number 8, "Documentation of disclosure must be placed in patient's health record".
CROSBIE, Q.C.:
Q. And the word "must" received emphasis, doesn't it?
MR. SINGLETON:
A. It does.
CROSBIE, Q.C.:
Q. It's in bold.
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:

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Q. And it's in italics, right?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. That didn't happen either, did it?
MR. SINGLETON:
A. No.
CROSBIE, Q.C.:
Q. So that's another stricture of these policies that your consult did not follow?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. Sir, you--to switch to another topic here, you have, you told us, experience in grief counselling?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. You also told us June 19th that the avoidability of the loss is significant to how people deal with the loss of loved ones. I'm quoting you from page 323.
MR. SINGLETON:
A. Yes.

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CROSBIE, Q.C.:
Q. And you told us--and here the reference would be 367 to 368, "The immensity of the grief", and you may have said "intensity", it may be a typo, I'm not sure, "of the grief and distress is probably intensified by many patients involved". That's what you said.
MR. SINGLETON:
A. Uh-hm.
CROSBIE, Q.C.:
Q. And I suggest, sir, this must be why it's important to know if the losses which may have been caused by failures in receptor testing were avoidable because it's important to people in the grief process to know that.
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. That's what you told us.
MR. SINGLETON:
A. That's right.
CROSBIE, Q.C.:
Q. Your consult assumed that they were not avoidable.
MR. SINGLETON:

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A. The information that--based on the statement that I made that there were no--something to the effect there were no mistakes or individuals that caused, is that what you-- is that your point on that?
CROSBIE, Q.C.:
Q. I'm putting it to you that you proceeded on the assumption that whatever had gone wrong was not something that could have been avoided?
MR. SINGLETON:
A. The discussion in the ethics consult pertaining to that was really about the relevance that people often--usually, actually, when there's a trauma of some sort in their life, want to know why something happened, but also people usually want to indeed get that information when they're ready to pursue it, and that was part of our discussion of why we would put the information out through the media and what have you that there is information available and people can come and get it by the means that would be set out for them to access the information, so that they can find out and discuss with the

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appropriate persons what was avoidable and what wasn't avoidable in their own case to the extent that it could be available for them.
CROSBIE, Q.C.:
Q. We can agree, sir, that information as to the avoidability or otherwise of the loss is important to the family members who are grieving?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. That information is important?
MR. SINGLETON:
A. Yes.
CROSBIE, Q.C.:
Q. Being given incorrect information, that would be important too, wouldn't it?
MR. SINGLETON:
A. Yes, it would.
CROSBIE, Q.C.:
Q. The lawyer for the insurance company was present and participated in your deliberations and we've seen that already, right?
MR. SINGLETON:
A. Yes.

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CROSBIE, Q.C.:
Q. He provided you with legal advice, you told us?
MR. SINGLETON:
A. Yes, he gave opinion on what would be the legal obligation around this--in such a situation.
CROSBIE, Q.C.:
Q. He gave you no advice as to any possible conflict of interest he might be in?
MR. SINGLETON:
A. No. I didn't ask people to declare conflict of interest or--at the start of the consult.
CROSBIE, Q.C.:
Q. It really never crossed your mind that some of the professionals might be in conflict of interest?
MR. SINGLETON:
A. No.
CROSBIE, Q.C.:
Q. And we've seen who was there, and there are various forms of expertise, but--Ms. Newbury has asked you this already, but it was not considered to be advisable to involve family members of deceased patients who are involved

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in this controversy for their input as to how it should it be handled?

MR. SINGLETON:

A. That's right.

CROSBIE, Q.C.:

Q. What do you understand by the term "quality assurance"?

MR. SINGLETON:

A. Quality?

CROSBIE, Q.C.:

Q. Quality assurance.

MR. SINGLETON:

A. The efforts and programs, standards, and all that are put in place to ensure the best processes and outcomes within health care, or any environment as far as that goes, and having systems in place to monitor and--monitor the performance or monitor the outcomes and processes.

CROSBIE, Q.C.:

Q. And to ensure that the policies that are in place are actually being followed?

MR. SINGLETON:

A. Yes.

CROSBIE, Q.C.:

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Q. How do you know if Eastern Health is following disclosure or any other policy? Do you have a QA system to sort that out?

MR. SINGLETON:

A. It wouldn't be my--it wouldn't be part of my domain to be monitoring those types of matters other than from the ethics involvements that we have as a resource to those who would be responsible for the administration of such things or the executive.

CROSBIE, Q.C.:

Q. I took it from your evidence earlier that you play a significant role in the origination of the policies that are adopted?

MR. SINGLETON:

A. That's the ethics role because so many of these things have an ethics component, and ethics principles, the core values of the organization and so on are foundational to many of those types of documents and policies and processes.

CROSBIE, Q.C.:

Q. Sir, one thing that struck me, I don't know about anybody else, but all the way through the evidence we've heard here, is that I can't

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remember anyone who says they pulled out the disclosure policies or any other policies of your institution and they sat down to read them. They're not that lengthy or hard to understand. Do you think that it would be a valuable exercise in quality assurance to seek to put in place a self-reporting mechanism so that periodically people would be asked are they having resort to the appropriate policies in resolving various issues, or to do an audit, do you think that would be of value?

MR. SINGLETON:

A. I think those types of things would be helpful. I think part of it is in big organizations like ours, there are so many things that people have to try and keep their fingers on that at times that--that type of maintenance activity doesn't take as high priority as it probably could.

CROSBIE, Q.C.:

Q. Some people had the distinct impression that these policies were spiffed up and polished, signed into existence, and put on the shelf and used as window dressings. Do you think that may have happened here?

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MR. SINGLETON:

A. I have--I'm not sure what--you know, Eastern Health is a big organization, 12,000 employees, and many physicians. That statement might be true about some people, it might be true about a good many, I'm not sure if it's true about everyone. So I--you know, I wouldn't be able to comment on the extent of the accuracy of that as a statement about Eastern Health generally.

CROSBIE, Q.C.:

Q. But if they're not to be mere window dressing, then a quality assurance program to ensure they're actually being looked at and put into effect might be a good idea?

MR. SINGLETON:

A. Oh, yes, sure.

CROSBIE, Q.C.:

Q. Sir, I'm getting near the end now you may be glad to know. You said in your earlier evidence, "don't ask me if I had my time back what I would have done". That's what I want to ask you, actually. Let's ask what you would have done differently if you did have your time back.

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MR. SINGLETON:
A. I guess I can speculate if I had my time back and knew then what we all know now, and I can't--I don't know as much as many others do about the complexities of this matter now. I think anyone within the domain of Eastern Health or the health care system generally, and lots of others, would approach that same situation differently if we knew what we were being asked to do when we received an ethics consult on the matter or what have you --
CROSBIE, Q.C.:
Q. I did say to the Commissioner specifically how you would handle this differently in a way that would improve the likelihood of a good outcome and a good consult.
MR. SINGLETON:
A. I'm not sure exactly what I would do differently. Certainly do more preliminary, search, or require more preliminary concrete history to the matter than informally collecting it by around the table type of conversation, which proved to be inadequate to my understanding of it because I was situating it in a framework that was--that really didn't

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apply to this type of broad-based or complex systemic problem. I was trying to separate out the type of case that we were dealing with and the disclosure issues there from what was happening from--you know, what we would do in individual cases, which was, you know, the type of document or the intention of the document that we went through. As you said earlier, and I think we would all see by now many of the principles and the spirit of that type of disclosure for individual cases could be applied more intentionally, and --
CROSBIE, Q.C.:
Q. Just to pause there for a second, not to disable you from adding your other thoughts at all. Do you think that explicit consideration of what's contained in the disclosure guidelines should be made during the consult when disclosure is an issue?
MR. SINGLETON:
A. There again it could be, you know.
CROSBIE, Q.C.:
Q. Surely the answer -
MR. SINGLETON:
A. I'm sure the more--the more documentation you

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have available, especially when you have to account for it later, which is quite different in this type of a consult than others. You know, most times when we do an ethics consult it's because there's something happening now - -
CROSBIE, Q.C.:
Q. But surely, sir, if disclosure is the issue, all parties that are participating should have explicit consideration of the foundational document that should govern them. So the answer to my question must surely be yes?
MR. SINGLETON:
A. Yes, yes.
CROSBIE, Q.C.:
Q. Thank you. Do you think you would have to go so far, in light of what may have happened here, to request--as to request declarations from those participating that they are not in conflict of interest?
MR. SINGLETON:
A. It may be something worth considering for the sake of how much effort it would be and to start an ethics consult. I think part of the consideration of the ethics consult is that by

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the nature of what's happening, people quite often have a--are in what might be in other situations described as a conflict of interest. If someone is attending as a health care professional physician or other, part of your role is to be an advocate for that individual patient. Sometimes the scope of the discussion is about situating the options of treatment or what have you for this individual patient in a broader context where the interest of the advocacy for that individual might not be the only consideration that has to be brought forward. So there's, I suppose, a measure of conflict of interest that would need to be accommodated, but knowing what the conflict of why the person is there would be important, and so--but it certainly wouldn't be a complicated or time consuming thing to do, and so to have that as part of the ethics consult process would be a good thing, yes.
CROSBIE, Q.C.:
Q. Do you think that the participants who had a special knowledge of the factual background of the occurrence, or technical knowledge for

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that matter, should be asked to declare that the factual background that they're communicating to the panel and to you is full and fair insofar as you need it to do your job, and set forward in good faith?

MR. SINGLETON:

A. Generally speaking, the people who attend those things are professionals, usually health care professionals.

CROSBIE, Q.C.:

Q. You expect that, don't you?

MR. SINGLETON:

A. Yeah, presumably, yes.

CROSBIE, Q.C.:

Q. You assume that that's what they're doing?

MR. SINGLETON:

A. Yes, yes. I mean -

CROSBIE, Q.C.:

Q. Do you think that they should actually have to declare that's what they're doing in light of what's happened here?

MR. SINGLETON:

A. Well, people have codes of ethics and what have you. When they're invited to attend something, they're coming forward from their

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profession with the knowledge-base they have and those types of things, and whether or not it would be needed in some cases or in all cases to have them declare conflict of interest, they could argue it one way or another. There are lots of times that people are well known to have their credentials and their codes of ethics, not all, but at the start of proceedings they may well also have to declare a conflict of interest, so it's not --it wouldn't be altogether new or different to do that, but back to your point, you presume that people will carry out their duties based on their own codes of ethics.

CROSBIE, Q.C.:

Q. Did that happen here?

MR. SINGLETON:

A. To my knowledge of it, it did.

CROSBIE, Q.C.:

Q. That's what you think today?

MR. SINGLETON:

A. I haven't seen, but I haven't followed every item and every discussion that's part of this inquiry or other discussions about it as well, so I have no reason to doubt the honesty or

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integrity of any of the people there.

CROSBIE, Q.C.:

Q. Could we have item--Document 2826 that was just entered brought up, please. Toward the middle of the first paragraph where my cursor is, it says, "Eastern Health core values of respect and integrity", those are the core values, I take it?

MR. SINGLETON:

A. Two of the core values, yes.

CROSBIE, Q.C.:

Q. Yes. Were they followed in their fullest sense in respect to the matter you were involved with?

MR. SINGLETON:

A. Well, actually at the time that that consult took place, our organization was just coming about, and so we were merging from seven previously separate organizations that had different core values, though somewhat similar and what have you, but, I mean, the essence of what's included in the core values would be similar to those and the others that are in Eastern Health core values, and if your question is were those core values --

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CROSBIE, Q.C.:

Q. Were the spirit and the letter of those values put into effect in the consultation process, not just your role in it, but the role of others as well?

MR. SINGLETON:

A. I mean, my understanding of it at the time is that it was being carried out. Subsequent to that, I know that others have disputed the-- whether or not information was given, whether it was asked for and what have you, but --

CROSBIE, Q.C.:

Q. So you --

MR. SINGLETON:

A. I'm not able to answer that really.

CROSBIE, Q.C.:

Q. You're not sure today? Today you reserve your judgment?

MR. SINGLETON:

A. Well, I can say that I can--that my understanding of the cause of these problems when we had that original ethics consult was different than it would be today in terms of how information was given and what have you. But I don't--I really can't answer that

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question. So to say I reserve my judgment, yes, that would be right.

CROSBIE, Q.C.:

Q. Thank you. My final question is do you feel you were manipulated by Eastern Health?

MR. SINGLETON:

A. No.

CROSBIE, Q.C.:

Q. Thank you. That's all I have for this realm.

THE COMMISSIONER:

Q. Thank you, Mr. Crosbie. Mr. Simmons, unless you're going to tell me you have no questions for this witness, which I'm doubting somehow, I suggest we take the morning break before we hear from you. Take 15 minutes.

(RECESS)

THE COMMISSIONER:

Q. Please be seated.

CROSBIE, Q.C.:

Q. Very briefly, Commissioner.

THE COMMISSIONER:

Q. Um-hm.

CROSBIE, Q.C.:

Q. This is in the nature of a remark, not a question. I would, on behalf of my class

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members and perhaps others, as well, ask Eastern Health to consider their position on making publicly available the report, apparently, by Dr. Gown, it would seem, that was referred to in the meeting that Mr. Singleton chaired, in the spirit of openness and transparency of communication. They can take that under advisement and let us know. Thank you.

THE COMMISSIONER:

Q. Mr. Simmons.

MR. RICHARD SINGLETON, EXAMINATION BY DANIEL SIMMONS

MR. SIMMONS:

Q. Thank you, Commissioner. Mr. Singleton, a couple of questions for you, several. First of all, can we have P-0056, please, page 18? This is the disclosure guidelines that you were shown earlier. And the title of this document is "Guidelines on Disclosure of Adverse Events." Now, I know that you've told us that you played a role in the drafting of this document and that it was fairly widely circulated within the organization and considered before it was adopted. Can you tell me if the use of the word "guidelines"

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here suggests anything in particular about how this was intended to be used?

MR. SINGLETON:

A. Well, guidelines lays out--this was, I'd say, some principles and concepts to be considered and approaches to be considered, but they aren't as binding as policies would be, and so they allow for some flexibility in the approach to a matter. Typically guidelines are about general types of matters, such as adverse, dealing with adverse events rather than as specific as how to do something which would be policy and quite precise in how it ought to be carried out. So guidelines generally would allow a broader approach and range of flexibility in dealing with a matter.

MR. SIMMONS:

Q. So in these guidelines where there are steps laid out, would you regard those steps as being mandatory or ones that were to be taken into account and considered?

MR. SINGLETON:

A. Yes, taken into account and to prompt consideration of approach and make the best fit with the situation.

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MR. SIMMONS:

Q. Okay. From your involvement in the preparation of these guidelines for disclosure of adverse events, do you know whether situations like that faced by Eastern Health with the ER/PR disclosures were contemplated or considered when the guidelines were drafted and prepared?

MR. SINGLETON:

A. No, not any discussion that I was part of or any work that I did.

MR. SIMMONS:

Q. Okay. In the ethics consult in June of 2006 I believe you've told us that these guidelines and disclosure were not explicitly referred to or referenced during the course of that consult, is that right?

MR. SINGLETON:

A. That's right.

MR. SIMMONS:

Q. Right. And that if I understand correctly, it didn't even come to your mind as a person intimately familiar with the drafting of these that this was a document that needed to be placed on the table and referred to at that

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time?
MR. SINGLETON:
A. That's right.
MR. SIMMONS:
Q. Nevertheless, in your participation did you take into account the types of underlying principles that were used when these guidelines were prepared and drafted and bring that to bear, in your participation in the ethics consult?
MR. SINGLETON:
A. Yes, I think so. And others who were there would, as well, such as the ethicists, at least those people.
MR. SIMMONS:
Q. Okay.
THE COMMISSIONER:
Q. Can we have an example, Mr. Simmons? As I have an aunt who when I was a child would always say, for instance, when she really wanted you to explain your behaviour. So I'm just thinking that was a broad statement and if I could have an example, I might be better able to understand how things are taken into account.

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MR. SIMMONS:
Q. Mr. Singleton, I'm going to pass that one on to you.
MR. SINGLETON:
A. Okay, yes. Well, the reference to values and to the rights of people to have information, those kinds of things, are important in the-- and the whole concept of respect and what have you are important in the core values of Eastern Health. They're brought forth in this type of a document and they're part of the discussions, as well, when we meet to have a discussion about a particular ethics consult. So, for example, in that particular discussion when it was raised that there isn't a legal obligation to provide the information to families of the deceased, we, and I think it was mentioned in the summary, we made the point, I did, at least, in the summary, but it was part of the discussion that even with that being the legal opinion that there isn't an obligation, we felt that there is an obligation to make it known to families that there is information because the respect for them, the obligation to allow them to know

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that there's something, that there might be information available that they could have access to and so on and so that would be the kind of spirit of it brought forward in the, you know, in the particular discussion.
MR. SIMMONS:
Q. Okay. Dr. Singleton, you've told us, you've described for us some examples of other types of ethics consultations. Would I be correct in saying that we could characterize them very broadly into two different types? There are those consultations which deal with issues of the care of a patient that is a current issue about what to do with someone who is under the care of professionals in the health care system at the time the consult is carried out?
MR. SINGLETON:
A. Yes.
MR. SIMMONS:
Q. That would be one type?
MR. SINGLETON:
A. Right.
MR. SIMMONS:
Q. And then the other type would be where there are--where there's consultation on issues of

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application more broadly, to a larger group of individuals or even hypothetically to unknown individuals in the future?
MR. SINGLETON:
A. Yes.
MR. SIMMONS:
Q. Would that be a fair way to characterize it?
MR. SINGLETON:
A. Yes.
MR. SIMMONS:
Q. Okay. And dealing first with the cases where it's a particular individual whose care is being considered and ethical issues have arisen with that, how--what is the binding effect, if any, of the decision from the ethics consult and how is it to be acted on or taken into account by those who actually are making the decisions about that person's care?
MR. SINGLETON:
A. Well, they are an ethics consult.
MR. SIMMONS:
Q. Um-hm.
MR. SINGLETON:
A. I think I described in the, when I was here in June that they are exactly that, a consult

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where a request is made for input from the ethics service and the discussion takes place and recommendations are brought forward, but they are recommendations from the consult to be taken and followed or to be set aside or to be integrated to the extent that they seem to fit with the plan in place by the person who has made the request. Along with that, because of documentation of the matters and what have you, there would be the--you know, if somebody chose not to accept the recommendation, then it would be--you know, they would need to account for why if it was disputed later, but to summarize it, it is a consult and the attending physician or the specific patient or whoever has the authority to make the decision about the matter would be the one who would make the decision.

MR. SIMMONS:

Q. Okay. In the second broad category that I identified where it's not a particular individual's patient, patient's care, what then is the status of the consult then, does it have any particular binding effect, is it mandatory, is it a recommendation, how is it

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carried forward?

MR. SINGLETON:

A. It generally would be about the same. It would be, you know, a consult and the opinions, you know, provided about the more broad based matter would be--or the recommendations would be taken into consideration to the extent that people, that they fit it in and that seem to match, you know, the basis on which the recommendation was brought about, or recommendations.

MR. SIMMONS:

Q. The ethics consult report from June of '06 is at P-0783, I think, please? 0783. Now, Mr. Singleton, I'll get this lined up. I'm going to take you to the first page and second-last paragraph there which reads, "The main ethical issue in this case pertains to disclosure. There are several considerations regarding the duty to disclose: The right of families to be informed of results from the retesting at Mount Sinai and who should manage the disclosure processes." And my question is, well, the--what was the issue or question that was brought to you for this ethics consult,

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specifically, what was the issue that the advice was being sought on?

MR. SINGLETON:

A. It was the reports that had come back from Mount Sinai on patients who had--who were dead.

MR. SIMMONS:

Q. And what was your understanding of what was in those reports?

MR. SINGLETON:

A. My understanding was that there may be--may have discovered that there were changes.

MR. SIMMONS:

Q. Yes.

MR. SINGLETON:

A. Or there might be retesting that was done where there hadn't been changes, as well.

MR. SIMMONS:

Q. Yeah. Was it your understanding that those were reports of the retest results for the ER/PR tests that had been redone at Mount Sinai?

MR. SINGLETON:

A. Yes.

MR. SIMMONS:

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Q. Yes. And that they were actually reporting whether there had been a change in the ER/PR score?

MR. SINGLETON:

A. Yes.

MR. SIMMONS:

Q. Or not?

MR. SINGLETON:

A. That's right, yes.

MR. SIMMONS:

Q. Okay, and what was it that you were being asked to have an ethics consult on in relation to those reports that had come back from Mount Sinai, what was the question about that?

MR. SINGLETON:

A. Well, the question was whether or not contact would be made to the families and how it would be done or is it--does it stop here because the patients are deceased and so there wouldn't be follow up.

MR. SIMMONS:

Q. Right.

MR. SINGLETON:

A. And I think -

MR. SIMMONS:

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Q. Contact to inform them of what?
MR. SINGLETON:
A. That there were results back from Mount Sinai.
MR. SIMMONS:
Q. Yes, okay.
MR. SINGLETON:
A. That there had been retesting.
MR. SIMMONS:
Q. Yes.
MR. SINGLETON:
A. And if my memory serves me correct, I think in--it wasn't really clear whether or not everyone would have known that there had been retesting and that this process had been done, so that was kind of part of it. But then the more substantial piece of it was, you know, is there a need to take an initiative to contact the families and then what are the issues around, you know, who and how to do that.
MR. SIMMONS:
Q. Okay, so is it correct to say, then, that the issue that was brought to you for the ethics consultation concerned communication of the retest results to families of the deceased?
MR. SINGLETON:

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A. Yes.
MR. SIMMONS:
Q. That was what was sought?
MR. SINGLETON:
A. That's right. And that's really important, too, because it wasn't about the whole history of all that had come about up to this point, but -
MR. SIMMONS:
Q. Right. So was the issue, was there any issue brought to you about what other information, if any, more broadly, should be disclosed to families and how, was that part of the mandate of this ethics consult?
MR. SINGLETON:
A. No, not really, no.
MR. SIMMONS:
Q. Okay. And just a couple of questions for you about participants at these ethics consults. You have facilitated many ethics consults aside from the two that we have reports on here, I presume?
MR. SINGLETON:
A. Yes.
MR. SIMMONS:

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Q. And you've told us back in June about some of the considerations that go into choosing who participates in those ethics consults?
MR. SINGLETON:
A. That's right.
MR. SIMMONS:
Q. And I gather from that that is it not unusual to have a lawyer involved in them?
MR. SINGLETON:
A. No, that's correct.
MR. SIMMONS:
Q. And what has been your experience with the value or not of having lawyers involved in these consults?
MR. SINGLETON:
A. Well, in cases that involve things that we know have specific piece of legislation that needs interpretation or new legislation or matters that may likely be disputed to the point that there may be, you know, legal action of one sort or another needed because of the issue of, you know, a person's competency and those types of things or matters of who makes decisions for whom when a person is incompetent and if it isn't clear by

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the act and by our own, you know, familiarity with the situation, then a lawyer may be needed. And sometimes the matters are complex to the point that we need someone to do research on a matter to, you know, give us the--an opinion so that as we do further ethics work that we have a sense of the scope of the legal matters that pertain to the issue.
MR. SIMMONS:
Q. You discussed this a bit back in June. And am I correct in taking out of what you've told us that the role of the lawyer is largely to sent the limits, outside limits of the range of action that's possible to take such that you know what is outside of what the law permits?
MR. SINGLETON:
A. That's right, what you can legally do and what you should legally not do.
MR. SIMMONS:
Q. Yeah, so you would need to know the legal obligations are, things that have to be done aside from the ethical considerations?
MR. SINGLETON:
A. That's right.

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MR. SIMMONS:
Q. Right? And what things legally you might be prohibited from doing aside from the ethical considerations?
MR. SINGLETON:
A. That's right, yes.
MR. SIMMONS:
Q. Okay. Now, had you had Mr. Boone participate in other ethical consults that you'd been involved in?
MR. SINGLETON:
A. Yes, he's been involved with at least two that I remember other than this one.
MR. SIMMONS:
Q. Okay, and can you provide me with any comment on whether his participation in those consults conformed to the kind of thing I've just described or not?
MR. SINGLETON:
A. Yes, he participated, you know, as the other lawyers would in cases and contributed, you know, very positively to the discussions.
MR. SIMMONS:
Q. Okay.
MR. SINGLETON:

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A. You know, in outlining the legal parameters.
MR. SIMMONS:
Q. Okay, and was his contribution to this particular consult in June of 2006 any different from that?
MR. SINGLETON:
A. No.
MR. SIMMONS:
Q. Thank you, Dr. Singleton, I don't have anything further for you. Thank you, Commissioner.
THE COMMISSIONER:
Q. Thank you.
CROSBIE, Q.C.:
Q. Commissioner I -
THE COMMISSIONER:
Q. Mr. Coffey?
CROSBIE, Q.C.:
Q. - want to raise a point which I don't know if it's order or procedure or what exactly, but -
THE COMMISSIONER:
Q. Um-hm.
CROSBIE, Q.C.:
Q. And, of course, I recognize that this proceeding is not a civil proceeding or in

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many ways not analogous to it, but it just struck me, there seems to be a practice of counsel retiring to a witness briefing room between testimonies of the witness and prior to doing what, in essence, much of it may be a redirect kind of examination.
THE COMMISSIONER:
Q. Um-hm.
CROSBIE, Q.C.:
Q. And I didn't object during the course of this because I'm not sure if it's a matter of any particular concern to the Commission or not, but I just raise it as a matter of procedure. I don't know if you've had occasion to consider whether that's something you desire or don't desire?
THE COMMISSIONER:
Q. I'm conducting this Inquiry on the basis that legal counsel are complying with ethical requirements regarding the testimony of witnesses who are on the stand.
CROSBIE, Q.C.:
Q. I don't mean to suggest that there's anything unethical going on.
THE COMMISSIONER:

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Q. Um-hm.
CROSBIE, Q.C.:
Q. Of course, I'm just pointing out that that would be frowned upon if it were in the court system for the reason that, you know, the idea is that the lawyer would be able to find out, now, what are you going to say if I ask you this and so forth and so on. So I just raise that. I'm not advocating one direction or another.
MR. BROWNE:
Q. Address at one point (inaudible).
THE COMMISSIONER:
Q. Well, if you want to have a free for all on this one, I suggest we deal first with this client, because--this witness. Then if the lawyers want to get involved in the discussion about procedure, we can deal with them, but let's deal with this witness so that he doesn't have to sit here while we discuss potential procedure issues. Mr. Coffey, are there any questions you want to raise in respect, reply?
MR. RICHARD SINGLETON, RE-EXAMINATION BY BERNARD COFFEY, Q.C.

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COFFEY, Q.C.:
Q. Yes, Commissioner, just a couple, please? Mr. Singleton, in responding to some questions this morning from other counsel, okay, you did, I believe, tell Mr. Crosbie, referring to knowing what we all know now, I think to use your exact words, what we all know now. Do you remember doing that?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. What were you referring to there, what is it from your perspective, knowing what we all know now, presumably compared to what you knew in June of 2006?
MR. SINGLETON:
A. That's right. Well, I'm not sure if I know in detail much more than I knew in 2006, but I know that certainly there's lots of evidence to show how systemic the problems were, that there have been a lot of experts who have studied and who have given reports and have made recommendations, even changes have come about already in the numerous components that are part of all this whole process that

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includes labs and operating rooms and all that's a part of it. So generally I can say that having the awareness that so many have that there were problems of one sort or another, some of them have probably been addressed and some will likely may be a continuous work that the matter that we were discussing and as we were discussing it wasn't as--it was in even a broader context than I understood it to be.
COFFEY, Q.C.:
Q. And Mr. Crosbie had said to you and linked, I believe, or had you link the idea or the statement that you'd made in your June 20th, 2006, I believe it is, report, "There were no mistakes or technical errors at the root of this problem" to the idea of whether or not the problem was avoidable. The idea being if there were mistakes or technical errors, arguably or potentially it was avoidable?
MR. SINGLETON:
A. Um-hm.
COFFEY, Q.C.:
Q. You remember that discussion with him this morning?

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MR. SINGLETON:
A. Yes, yes.
COFFEY, Q.C.:
Q. And I take it then, and correct me if I'm wrong, that in referring to what we all know now, you are referring to aspects of this matter that suggests, perhaps, that the problem was potentially avoidable? Would you agree with that?
MR. SINGLETON:
A. Oh, yeah.
COFFEY, Q.C.:
Q. That's what you -
MR. SINGLETON:
A. Yeah, I mean, I presume that -
COFFEY, Q.C.:
Q. You've learned since -
MR. SINGLETON:
A. - all of this is about at least trying to reduce the number or contributing factors and the intensity and correct matters and prevent further repeats of the same thing.
COFFEY, Q.C.:
Q. Now, one final point then, Doctor, is--I'm sorry, Mr. Singleton, is is this, is it was

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canvassed with you by other counsel the notion of, and particularly Mr. Crosbie, good faith, you're assuming good faith from those you've invited to the meeting?
MR. SINGLETON:
A. Sure, yes.
COFFEY, Q.C.:
Q. On behalf of them. And good faith in that context, I take it, would include passing on whatever information they have that's germane to the issue?
MR. SINGLETON:
A. Yes.
COFFEY, Q.C.:
Q. Kind of not having to be cross-examined about it, actually just to pass it freely and forthright offer it?
MR. SINGLETON:
A. Exactly, to contribute and share it openly on what, you know, what matters to the discussion that's happening.
COFFEY, Q.C.:
Q. And at the time, then, would it have been of interest to you to be told about what was known at the time about internal controls and

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the problem with the observations concerning people ignoring the usage of internal controls or having them there but not apparently paying any attention to them, would that have been of interest to you at the time, on June 20th?

MR. SINGLETON:

A. Yes, I think so, yes, yes.

COFFEY, Q.C.:

Q. The idea of fixation problems, tissue processing problems, the way tissue is preserved, the fact that that had been identified quite sometime before would have been of interest to you at the time?

MR. SINGLETON:

A. It likely would, I mean -

COFFEY, Q.C.:

Q. In terms of being avoidable, avoidability issue?

MR. SINGLETON:

A. I mean, for me and others like me who are not scientists and physicians and so on, the implications of those things would need to be part of it. But that's what we would, you know, like to have as part of the discussion, sure.

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COFFEY, Q.C.:

Q. And, as well -

MR. SINGLETON:

A. As well the facts.

COFFEY, Q.C.:

Q. - the, I mean, you've referred to what we wall know now or you understand now, having somewhat followed what's gone on before the Commissioner here, the observations by outsiders, in particular, Ms. Wegrynowski, that there were no--very little in the way of written policies or procedures, record keeping was deficient and so on and certain procedures within the lab that she observed and she thought were deficient?

MR. SINGLETON:

A. Yes.

COFFEY, Q.C.:

Q. Like not calibrating pipettes, for example?

MR. SINGLETON:

A. Yeah.

COFFEY, Q.C.:

Q. So those sorts of things would have been useful to know on June 20th?

MR. SINGLETON:

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A. Oh, I think so, yes.

COFFEY, Q.C.:

Q. Do you know now if some of the people who were in that room knew those things at that time?

MR. SINGLETON:

A. They -

COFFEY, Q.C.:

Q. That's your understanding?

MR. SINGLETON:

A. I don't know if they did or not, I haven't -

COFFEY, Q.C.:

Q. Somebody like Dr. -

MR. SINGLETON:

A. - followed what they're doing, but in the meantime, they weren't asked to come to bring that type of information, it wasn't asked. And so I guess for many of them it was probably their first time, I think most of them it was probably their first time and maybe only time participating in an ethics consult and so they probably stayed more focused on the specific matter that the ethics consult was about, which were the retest reports that had come back.

COFFEY, Q.C.:

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Q. Just so the Commissioner is clear on this, at the outset of that meeting the events that had lead up to you having to sit around the table to discuss what you do with the deceased's test results, the background of this problem was canvassed in front of those oncologists and pathologists?

MR. SINGLETON:

A. Yeah, um-hm.

COFFEY, Q.C.:

Q. I'm correct on that, am I?

MR. SINGLETON:

A. Yes.

COFFEY, Q.C.:

Q. So the Commissioner is clear here.

MR. SINGLETON:

A. Yeah.

COFFEY, Q.C.:

Q. What you would have understood was kind of a full, fair and frank discussion of those matters?

MR. SINGLETON:

A. Yes, yes.

COFFEY, Q.C.:

Q. You knew nothing about it and they were

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supposed to tell you?
MR. SINGLETON:
A. That's right, exactly.
THE COMMISSIONER:
Q. Now you perhaps dealt with this the last time, Mr. Singleton, but if you did, forgive me and I'll ask it again. When you have consults such as this, do you do a sort of general introduction saying this is how it works, this is how I see my role, this is how I see the role of the ethicists who are here, this is how I see your role?
MR. SINGLETON:
A. Yes, actually, it's done, I suppose, several layers of that in that when we send out an e-mail or make phone calls to people some are, you know, haven't had previous involvements with the ethics consultation -
THE COMMISSIONER:
Q. Well that's what I'm wondering about, you've raised -
MR. SINGLETON:
A. I'll give them a bit of background in what it is and what the purpose is. Sometimes they know already, but anyway, we--and then at the

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start of the meeting just, you know, a kind of a short introduction of what an ethics consult is and how things are handled and, you know, just kind of lay out the ground rules, you might say.
THE COMMISSIONER:
Q. And, for example, things like the good faith requirement that you've referred to during your testimony, would that be made clear to them?
MR. SINGLETON:
A. No, because I think I kind of presumed that that would be -
THE COMMISSIONER:
Q. You assume that comes with their ethical conduct?
MR. SINGLETON:
A. That's, yeah.
THE COMMISSIONER:
Q. Well, that's what I'm trying to, I think, distinguish between what you might have said to people about what you expected of them in terms of their participation.
MR. SINGLETON:
A. Yes.

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THE COMMISSIONER:
Q. And what you assumed because you're, as I understood this morning, assuming that those who--professional people come with a certain level of ethical conduct attached to them by virtue of their particular professions?
MR. SINGLETON:
A. Yes.
THE COMMISSIONER:
Q. And so the discussion you have about roles doesn't include, for example, something like, you know, we're all working here on the basis of good faith and if you have knowledge that could assist us in dealing with this particular issue, I would expect you to provide that to the group, blah, blah, blah?
MR. SINGLETON:
A. No, that's right, we do a short introduction or orientation, might say, but we--I haven't, at least, in any sessions that I've facilitated nor has that instruction been given by me to others who facilitate the process.
THE COMMISSIONER:
Q. Okay, then. Thank you. Thank you once again

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for coming back after such a long period of delay. I regret it had to be so long, but I'm afraid we got tied up with other schedules and items. Thank you, very much. Now, Mr. Simmons, you were on your feet. You wanted to deal with the issue raised by Mr. Crosbie. And I believe, Mr. Browne, you also want to weigh in. I'll give other counsel who wish to weigh in an opportunity, as well.
MR. SIMMONS:
Q. Thank you, Commissioner. I was taken somewhat by surprise by Mr. Crosbie's comments. He hadn't mentioned anything to me beforehand, before raising it here. This is not a civil proceeding, of course. The witnesses are the Commission's witnesses, which is somewhat different. But even if it were a civil proceeding, as Mr. Crosbie knows, had this been a trial and had Mr. Singleton been my witness and I had called him at the trial and he had been cross-examined and cross-examination was completed, during the cross-examination there are rules that limit counsel's access to that witness. But once cross-examination is complete, then cross-

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examination is complete and counsel again do have access to their witness before redirect, that's the way I understand it would work in a civil trial. Of course, this is not the case here. Throughout this Inquiry all the witnesses have been the Commission's witnesses. Those who have counsel representing them have been meeting freely with their counsel throughout as has been known to all the participants here and I presume would have been known to Mr. Crosbie, as well, so as I say, I was taken somewhat by surprise by his comments. And I don't believe there is anything inappropriate in these circumstances in counsel for the witnesses continuing to have some contact with them. However, if there is some guidance, Commissioner, that you want to give us on that at this stage, we'd certainly appreciate your views on it.

THE COMMISSIONER:

Q. Mr. Browne.

MR. BROWNE:

Q. Thank you, Commissioner. That was the only observation I was going to make, as well, that

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distinction which was just brought forward by Mr. Simmons.

THE COMMISSIONER:

Q. Mr. Pritchard?

MS. BRAZIL:

Q. I agree, I guess, that we were going to make a comment, Madam Commissioner, but Mr. Simmons' assessment of what we understood the rules to be is accurate.

THE COMMISSIONER:

Q. Ms. Newbury?

MS. NEWBURY:

Q. (Inaudible).

THE COMMISSIONER:

Q. Mr. Pritchett?

MR. PRITCHETT:

Q. Nothing beyond what's already said.

THE COMMISSIONER:

Q. Mr. Pike?

MR. PIKE:

Q. Nothing, thank you.

THE COMMISSIONER:

Q. Commission counsel want to add?

COFFEY, Q.C.:

Q. Nothing, Commissioner.

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THE COMMISSIONER:

Q. All right. Mr. Crosbie, this, as counsel have pointed out, is a long-standing practice which we have adopted. The making available of a separate facility for counsel and the witnesses was done by us early in the game. It was my view that the process of giving evidence at this hearing was likely to be very stressful for the witnesses, perhaps some more than others. Some have a better and perhaps more experience in dealing with public circumstances and might be able to handle the attention which one receives when one is a witness at this hearing more easily. And my view was that it was important that we provide for those individuals a place where they could feel that for a few moments they could relax with sometimes family or friends who are with them to support them or their counsel who at least has been my observations witnesses in this hearing seem to rely on for support. And I'm not convinced that we need to change that pattern of behaviour, at least at this stage. As I've said before, I have assumed and will continue to assume that the conduct of the

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counsel involved will be in keeping with the ethical principles applicable to them. You wanted to -

CROSBIE, Q.C.:

Q. I wasn't raising the matter as an objection, but really to seek the Commissioner's clarification, which you've now given.

THE COMMISSIONER:

Q. Yes.

CROSBIE, Q.C.:

Q. Nor did I intend to take anyone off guard or surprise anybody or imply that anything unethical had occurred. It was just by way of an inquiry. Thank you.

THE COMMISSIONER:

Q. All right, then. Thank you, Mr. Crosbie. Now, Mr. Coffey, do you have another witness?

COFFEY, Q.C.:

Q. Yes, the next witness, yes, I do, Commissioner. The next witness is Renee Pendergast.

MS. RENEE PENDERGAST (SWORN) EXAMINATION BY BERNARD COFFEY, Q.C.

REGISTRAR:

Q. Would you please state and spell your full

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name for the record?
MS. PENDERGAST:
A. Renee Pendergast, R-E-N-E-E, P-E-N-D-E-R-G-A-S-T.
REGISTRAR:
Q. Thank you.
THE COMMISSIONER:
Q. Mr. Coffey?
COFFEY, Q.C.:
Q. Thank you, Commissioner. Commissioner, I just at the outset want you to know I propose to have Ms. Pendergast, of course, explain to you who she is, kind of what the nature of her involvement in this is. She is witness whom we, we being Ms. Chaytor and I, as Commission counsel, certainly interviewed along with many others before the hearings began and even since the hearings have begun. We had not, because we have to make some judgment call about who to call, had not planned to call Ms. Pendergast ourselves, but upon receiving a request from counsel for Her Majesty, certainly have arranged to have Ms. Pendergast appear. So what I'm going to propose, Madam Commissioner, is is this, I will take Ms.

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Pendergast through her background and kind of why she's ended up here. There are certain things or certain aspects of this matter I understand that Ms. Brazil wishes to explore with her.
THE COMMISSIONER:
Q. Um-hm.
COFFEY, Q.C.:
Q. Ms. Brazil, I've spoken to, she's prepared to do so at that point because it'll directly focus the matter. Then any other counsel, presumably, who have questions would ask them. I've advised Ms. Brazil that in the circumstances here because it's relatively unique and that we did not initiate calling this witness that if I had any questions, I would ask them and if there's anything at the end that Ms. Brazil feels necessary to qualify or to clarify, she can do that with the witness.
THE COMMISSIONER:
Q. So essentially we're treating Ms. Brazil, treating the witness as your witness, more or less?
COFFEY, Q.C.:

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Q. Yes.
MS. BRAZIL:
Q. That's not--I think we probably need to understand--I just spoke to Mr. Coffey about this a few minutes ago. My understanding is that she would still be considered a Commission witness, Commissioner, but that because I think my understanding from Mr. Coffey was the reason he prefer I take her through some of the questions that it'll probably expedite.
COFFEY, Q.C.:
Q. Yes.
MS. BRAZIL:
Q. Ms. Pendergast's testimony and as a result I'm assuming that I could lead her.
COFFEY, Q.C.:
Q. Yes. And I'm certainly going to be suggesting if necessary, you know, in the circumstances, yes, that she did, yes. I have no -
THE COMMISSIONER:
Q. Okay. We'll have to see how it goes.
COFFEY, Q.C.:
Q. Yes.
THE COMMISSIONER:

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Q. All right.
COFFEY, Q.C.:
Q. Thank you. Ms. Pendergast, could you tell--you've told the Commissioner your name. What's your occupation, please?
MS. PENDERGAST:
A. My occupation is currently I'm the manager of the Access to Information and Protection of Privacy office within the Department of Justice.
COFFEY, Q.C.:
Q. Okay. And could you then give the Commissioner and outline of your educational and professional background?
MS. PENDERGAST:
A. My background is in information technology and information management and most recently access and privacy and focusing in access and privacy. It's been done at the university level and at a college level. I've most recently enrolled in the access and privacy certification, an national wide certification at the University of Alberta. And I've been involved directly with ATIPP since its introduction with the Government of

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Newfoundland since January of 2005.
COFFEY, Q.C.:
Q. And how did you end up or come to be involved with ATIPP?
MS. PENDERGAST:
A. ATIPP was the legislation was proclaimed in January of 2005. I was currently employed as the manager of information management at the Royal Newfoundland Constabulary and when the legislation was proclaimed and it was at that time that I took on the coordinating role at the Royal Newfoundland Constabulary as their ATIPP coordinator.
COFFEY, Q.C.:
Q. And from there?
MS. PENDERGAST:
A. From there I spent about two years currently in that position. In 2006 I accepted a position within the Department of Justice at the Confederation Building as their manager of ATIPP for that particular division within the Department of Justice.
COFFEY, Q.C.:
Q. And from there?
MS. PENDERGAST:

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A. From there in 2007 I was asked to come on board with Cabinet Secretariat and I was seconded to Cabinet Secretariat as their manager of information management for that particular division within government and I also took on the role as the access and privacy coordinator for Cabinet Secretariat.
COFFEY, Q.C.:
Q. And when in 2007 was that?
MS. PENDERGAST:
A. That was in June of 2007.
COFFEY, Q.C.:
Q. And you continued in that role until -
MS. PENDERGAST:
A. Until September of this year.
COFFEY, Q.C.:
Q. Of?
MS. PENDERGAST:
A. 2008.
COFFEY, Q.C.:
Q. This month?
MS. PENDERGAST:
A. Yes.
COFFEY, Q.C.:
Q. Okay, and you since this month -

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MS. PENDERGAST:
A. I've since gone back to my permanent position as back to the manager of the ATIPP office within Justice.
COFFEY, Q.C.:
Q. Okay. Could you outline for the Commissioner, please, what the role was that you first took on at the Department of Justice in 2006?
MS. PENDERGAST:
A. In 2006. My role was I--the position was manager of the ATIPP office.
COFFEY, Q.C.:
Q. In practice what does that mean, what -
MS. PENDERGAST:
A. The responsibilities of that particular role is that the office is designed to provide guidance, support, training to all the 460 bodies affiliated under the ATIPP legislation, to show them, you know, how to process requests, how to properly interpret sections of the legislation, training of how to properly process ATIPP requests, walk them through the appeal process with the privacy commissioner's office, which is, you know, the recourse for somebody to appeal if they're not

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entirely happy with the ATIPP process and that sort of nature.
COFFEY, Q.C.:
Q. So and this body in the Department of Justice, is there a similar body in any other department?
MS. PENDERGAST:
A. No.
COFFEY, Q.C.:
Q. Okay, so perhaps you could explain that to the Commissioner?
MS. PENDERGAST:
A. Under the legislation it states that in every department or every--all those 460 bodies across government the legislation states that every single one of those bodies has to designate an ATIPP coordinator and that ATIPP coordinator would be responsible for processing and properly handling any requests that may come in to those particular agencies, departments, municipalities, health boards, school boards, it's a vast array of public bodies. Our office at the ATIPP at the Department of Justice is to kind of manage those ATIPP coordinators to ensure that they

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know how to properly process the request for anybody new who's coming in who has never particularly processed a request before, providing any guidance with regards to past case laws by the OIPC's office, which is the privacy commissioner's office, any interpretation of making sure, you know, time lines are met and things of that nature.

COFFEY, Q.C.:

Q. So they're a Justice Department group or that office?

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. That you headed in '06 and now again in '08?

MS. PENDERGAST:

A. Yes.

COFFEY, Q.C.:

Q. How many are in the staff there?

MS. PENDERGAST:

A. We have about six on staff right now.

COFFEY, Q.C.:

Q. And they are, I take it, an educative and consultancy service?

MS. PENDERGAST:

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A. Absolutely.

COFFEY, Q.C.:

Q. For the ATIPP coordinators throughout government?

MS. PENDERGAST:

A. Yeah, we administer the act, um-hm. Our department is responsible, Department of Justice is responsible for administering the act.

COFFEY, Q.C.:

Q. Yeah, well, on that point, what does that word "administer" mean in the context of the relationship between your office and, for example, the ATIPP coordinator in health?

MS. PENDERGAST:

A. The ATIPP--any time an ATIPP request comes in with regard--well, let's use the Department of Health. If an ATIPP request was to be submitted to the Department of Health, we in the ATIPP office have what we call a trim database that keeps track of all requests that would come in to any other 460 bodies. So the ATIPP coordinator with health would input that data into what we would call our ATIPP database that we administer and we monitor, so

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we keep track of all the statistics for any ATIPP request across government agencies. And if that coordinator in particularly the Department of Health had any concerns or any questions relating to how he or she may process a request, they would call our office for any guidance.

COFFEY, Q.C.:

Q. Does your office routinely vet the responses?

MS. PENDERGAST:

A. No. That's solely the responsibility of the particular department that would have been in receipt of an ATIPP request.

COFFEY, Q.C.:

Q. So you are advised of any ATIPP request?

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. All these coordinators have to tell your office -

MS. PENDERGAST:

A. Exactly.

COFFEY, Q.C.:

Q. Communicate with your office that there is such an ATIPP request and what it is?

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MS. PENDERGAST:

A. Yes, absolutely.

COFFEY, Q.C.:

Q. You track it in the sense of keep track of they have to tell you finally then if it's responded to and you keep track of it, you keep track of that?

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. Incoming, what it is, outgoing, what it is. Does your office keep track of what's actually sent out?

MS. PENDERGAST:

A. No. That's again, all of those particular records are kept in the department.

COFFEY, Q.C.:

Q. Kept in the department itself. So within the Department of Justice you're told that there is a request. Are you told what the request is?

MS. PENDERGAST:

A. Yes, we're told what the request is.

COFFEY, Q.C.:

Q. And you're told the date the request is

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responded to?
MS. PENDERGAST:
A. Exactly. And we're told once it's concluded, once the particular ATIPP coordinator in the department has concluded their file, we're told whether or not it was partially disclosed, fully disclosed, what exceptions were used for the severing, if any was done, and what date it was sent out, if there was an extension applied, which are things under the legislation, and we do that because we have to report on it annually, our minister.
COFFEY, Q.C.:
Q. And I take it if there's an appeal and that department or agency becomes aware of it, they have to let your office know, as well?
MS. PENDERGAST:
A. Absolutely. We track those statistics, as well.
COFFEY, Q.C.:
Q. You keep track of that, okay. And you answer any questions that they have or act as a consultant?
MS. PENDERGAST:
A. Absolutely, for processing or anything of that

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THE COMMISSIONER:
Q. But you have nothing to do with content?
MS. PENDERGAST:
A. No. We solely leave that within the department.
COFFEY, Q.C.:
Q. Okay. And, Ms. Pendergast, in June, 2007 you ended up in a new position?
MS. PENDERGAST:
A. Yes.
COFFEY, Q.C.:
Q. And that again was what?
MS. PENDERGAST:
A. That was the Manager of Information Management and ATIPP Coordinator for Cabinet Secretariat.
COFFEY, Q.C.:
Q. Okay, and what was the nature of those responsibilities?
MS. PENDERGAST:
A. I was responsible for monitoring and managing all of the records at Cabinet Secretariat, both electronic and hard copy. Cabinet records would be the majority of those, since we were Cabinet Secretariat and we are the

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keepers of those particular types of records, and my responsibility would also be to process any requests that would have directly come in to Cabinet Secretariat.
COFFEY, Q.C.:
Q. Okay, and now to go back to your role in Justice, as the head of that office in the Justice Department, does your office, or you as the head of it, have any authority to direct an ATIPP coordinator as to what he or she should do?
MS. PENDERGAST:
A. You mean as the manager of the ATIPP office?
COFFEY, Q.C.:
Q. Yes.
MS. PENDERGAST:
A. No. We can make recommendations, we can show coordinators across government how the OIPC office has ruled on cases similar in the past and show them direction and guidance in that way, but we--no, we only have recommendations and if they choose to follow that, that's entirely at their discretion.
COFFEY, Q.C.:
Q. To go back then to the Executive Council

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position in 2007, did you have any directory or authoritative role there?
MS. PENDERGAST:
A. The role at Cabinet Secretariat is probably--the ATIPP, I should say, coordinator role at Cabinet Secretariat is a little different than you would see in any other ATIPP coordinating role across government, and that being because we are a central agency for government. We see--we have a broader view of what is going on in all the departments. So as the ATIPP coordinator for Cabinet Secretariat, I also got involved with ATIPP requests across government that may have been submitted to various government departments. So it's a little different than what a regular ATIPP coordinator in one specific department would be responsible for.
COFFEY, Q.C.:
Q. And different in what way?
MS. PENDERGAST:
A. We do a lot of consultations from a Cabinet Secretariat point of view. The two areas where we are brought in to consult on each requests that aren't directly submitted to

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Cabinet Secretariat would be when Sections 20 in the ATIPP legislation, which is policy, advice, and recommendations a minister or public body, and Section 18, which is our mandatory exception, which is Cabinet confidence. We are brought in any time those two particular sections are invoked to any government department.

COFFEY, Q.C.:

Q. So you are brought in by whom?

MS. PENDERGAST:

A. Brought in by the coordinators in the various departments amongst government.

COFFEY, Q.C.:

Q. Oh, they know --

MS. PENDERGAST:

A. Yes.

COFFEY, Q.C.:

Q. The are instructed to contact you.

MS. PENDERGAST:

A. They are trained--they are trained and told that, you know, any time these particular two sections are looked on as to sever information under, that --

COFFEY, Q.C.:

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Q. To sever or potentially to sever?

MS. PENDERGAST:

A. Or potentially sever, you would--you should bring in the ATIPP coordinator at Cabinet Secretariat for a consult.

COFFEY, Q.C.:

Q. And are there any others that would routinely --any other types of ATIPP requests, Section 20, 20 --

MS. PENDERGAST:

A. 18.

COFFEY, Q.C.:

Q. 18, I'm sorry, 18 and 20. Any others?

MS. PENDERGAST:

A. There are some rare ones where, you know, if there is anything that are a matter of public interest, then we may very well be brought in on those as well. Those are rare.

COFFEY, Q.C.:

Q. And in the role as the ATIPP coordinator for the Cabinet Secretariat, I appreciate you've told the Commissioner other than some rare instances where the public interest might cause the ATIPP coordinator in their department to send it on --

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MS. PENDERGAST:

A. Uh-hm.

COFFEY, Q.C.:

Q. To your office, and the Section 18 and 20 situations, how about in terms though of as that in the ATIPP coordinator for the Cabinet Secretariat, your ability to give direction?

MS. PENDERGAST:

A. When we are brought in to consult with various departments on an particular ATIPP request, you know, we speak very frankly. I speak--I'll speak while I was there. I spoke very frankly with the coordinators on what our recommendations would have been after we see the documents. In the legislation, it also states that the decision to what to disclose or withhold in an ATIPP request solely lies with the department who is in receipt of it, so--however, you know, we could make recommendations. If the department chose to follow them, that was entirely up to the head of the public body to make that decision.

COFFEY, Q.C.:

Q. So as the ATIPP coordinator for Cabinet Secretariat, if you're consulted and saw fit,

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you would provide your opinion?

MS. PENDERGAST:

A. Uh-hm.

COFFEY, Q.C.:

Q. And--but you're telling the Commissioner because of the way the ATIPP Act is structured, that you wouldn't actually have the legal authority to force the issue?

MS. PENDERGAST:

A. To force the issue, exactly.

COFFEY, Q.C.:

Q. From your own perspective, though, if as the ATIPP coordinator for the Cabinet Secretariat, you were to give an ATIPP coordinator some advice --

MS. PENDERGAST:

A. Uh-hm.

COFFEY, Q.C.:

Q. In particular, in relation to the application of Section 20 --

MS. PENDERGAST:

A. Uh-hm.

COFFEY, Q.C.:

Q. Would you expect it to be followed?

MS. PENDERGAST:

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A. For the most part, it is followed, yes.
COFFEY, Q.C.:
Q. Commissioner, I'm going to now suggest that Ms. Brazil--she has some things in mind.
THE COMMISSIONER:
Q. Ms. Brazil.
MS. BRAZIL:
Q. Thank you.
MS. RENEE PENDERGAST - EXAMINATION BY MS. JACQUELINE BRAZIL
MS. BRAZIL:
Q. Ms. Pendergast, I'm going to ask you some specific questions now about a particular ATIPP request that you were involved with, I believe, shortly after you took on your secondment at Cabinet Secretariat.
MS. PENDERGAST:
A. Uh-hm.
MS. BRAZIL:
Q. It's an ATIPP request that you--that came in through Health and Community Services, and you were consulted on. So I'm just going to ask you to explain to the Commissioner what transpired with respect to that request?
MS. PENDERGAST:

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A. Shortly after I took the position as the ATIPP coordinator of Cabinet Secretariat, a request came in on the particular ER/PR issues. They involved--once the Department of Health's coordinator did his original review of the records, he saw that there was Sections 18 and 20, or what he perceived to be Sections 18 and 20.
MS. BRAZIL:
Q. I'm just going to stop you there for one second. Can you explain to the Commissioner what Section 18 of ATIPP, what does that involve or what's that pertaining to?
MS. PENDERGAST:
A. Section 18 is--you know, in the legislation we have what we call mandatory exceptions and discretionary exceptions. We have three mandatory exceptions, one of them being Section 18, which is our Cabinet confidence sections.
MS. BRAZIL:
Q. Okay.
MS. PENDERGAST:
A. It states that, you know, under no circumstances are documents to go out that we

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deem to be a Cabinet confidence if it would reveal the substance of deliberations of Cabinet. So those are records that, you know, are withheld under those particular mandatory exceptions.
MS. BRAZIL:
Q. Okay, and Section 20?
MS. PENDERGAST:
A. Section 20 is one of our discretionary exceptions and that states that any advice or recommendations made for or about a minister or public body you can also withhold those on a case by case, line by line basis. It's at the discretion of the particular agency or department that's processing an ATIPP request.
MS. BRAZIL:
Q. Okay. So I believe what you told Mr. Coffey was that Cabinet Secretariat is automatically consulted if an ATIPP request touches on issues with respect to Section 18 or Section 20?
MS. PENDERGAST:
A. Yes, that's correct.
MS. BRAZIL:
Q. And that's what brought you into this request

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that came in to Health and Community Services, is that correct?
MS. PENDERGAST:
A. Yes, that's correct.
MS. BRAZIL:
Q. Okay, so can you just continue on from there?
MS. PENDERGAST:
A. Once the ATIPP coordinator in the particular department who received the request identifies that he or she feels that things may be 18 or 20, they are usually--those particular records and copied and sent to--at that time, it would have been me at Cabinet Secretariat. I review the records to see, first of all, if they actually do meet the criteria under Sections 18 and 20. I confirm if documents are just that, a Cabinet confidence, and to ensure that we are applying the proper exemptions. The same thing for 18, I look at it to ensure that, you know, does it or would it reveal advice or recommendations provided to a minister, and that's where my consultation would begin.
MS. BRAZIL:
Q. Right. So with this particular request, and

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let's deal with it, Section 18 wasn't an issue, I understand, is that right?

MS. PENDERGAST:

A. Section 18 wasn't an issue, you're right.

MS. BRAZIL:

Q. Okay, so Section 20, you had some discussion with Mr. Coates regarding Section 20?

MS. PENDERGAST:

A. Section 20, there were some documents in the package that we were processing for the applicant that we were having a difference of an opinion on the interpretation of Section 20.

MS. BRAZIL:

Q. Right, and that was particularly--just trying to move this along here. You believed that it was advice to the minister, is that correct?

MS. PENDERGAST:

A. Yes, that's true.

MS. BRAZIL:

Q. And Mr. Coates did not, is that correct?

MS. PENDERGAST:

A. Yes.

MS. BRAZIL:

Q. But your recommendation to him was to remove

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that portion of the document because it was a discretionary exemption?

MS. PENDERGAST:

A. Absolutely.

MS. BRAZIL:

Q. Under--exception, I think I should say, under Section 18, is that correct?

MS. PENDERGAST:

A. Section 20.

MS. BRAZIL:

Q. Section 20, sorry, yes.

MS. PENDERGAST:

A. Yes, there were documents in there that I deemed that they were written with the intent to provide advice and recommendations to a minister, and, therefore, it was my recommendation that that information should have been withheld under Section 20(1)(a) of the legislation.

MS. BRAZIL:

Q. And you felt that that was in compliance with the legislation?

MS. PENDERGAST:

A. Absolutely.

MS. BRAZIL:

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Q. Is that correct?

MS. PENDERGAST:

A. It was my interpretation of those particular documents and of the legislation that they fell within that particular 20(1)(a) of ATIPP legislation and, therefore, should have been withheld.

MS. BRAZIL:

Q. Now there was some discussion about Section 30 as well, was there not, Ms. Pendergast?

MS. PENDERGAST:

A. Yes, there was. In the Section 20 of our legislation is another mandatory exception, and it's what we consider our personal information exception, under no circumstances is anybody name, address, date of birth, and I could go through an array of, you know, definitions of what we consider to be personal information. Under no circumstances are they to go out in any government type records.

MS. BRAZIL:

Q. Right.

MS. PENDERGAST:

A. The only exception being that if you are an employee of a public body, civil servant,

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public service role, then, yes, your name and that would be able to go out.

MS. BRAZIL:

Q. Okay.

MS. PENDERGAST:

A. But anybody that's considered to be, I guess, a private citizen, we would withhold those particular pieces of personal information from government records.

MS. BRAZIL:

Q. Right. Now did yourself and Mr. Coates have some discussion with respect to third parties who were named in some of the documents?

MS. PENDERGAST:

A. Yes. In the documents there were some names of individuals involved in the ER/PR issue that he had decided to leave those names in, and after I was looking through the records during my consultation phase, I realized that, you know, we should not be including those names and they should be severed before the package was to be disclosed to the applicant. So I brought that to the attention of the ATIPP coordinator with Health and Community Services and we had some discussions over

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that.
MS. BRAZIL:
Q. Right, and how was that resolved?
MS. PENDERGAST:
A. Well, there was an interpretation issue on whether or not those names were already out into the public domain.
MS. BRAZIL:
Q. Right. Were you aware that they were already out in the --
MS. PENDERGAST:
A. Absolutely. I mean, I was aware that they were out in media outlets and--you know, they were in numerous areas of, I guess, the public domain, but --
MS. BRAZIL:
Q. But it was still your--sorry, but it was still your recommendation that they be removed?
MS. PENDERGAST:
A. Absolutely. Under the legislation, we are very firm in the ATIPP legislation. There is no harms test to say that under these circumstances we can release personal information, there's nothing like that in our legislation right now. It is very firm on the

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fact that personal information, if you are not a public service employee, any remuneration, details like that, if you're a private citizen, you do not release that information. So for that reason alone I decided that looking through strictly a legislative lens that those names should be withheld, and I strongly recommended that to the coordinator at Health and Community Services.
MS. BRAZIL:
Q. And is that still your interpretation of Section 30?
MS. PENDERGAST:
A. That is absolutely--to this day, until or if we change our legislation to put a harms test in, that's still the lens that I look through when I'm processing ATIPP requests, yes.
MS. BRAZIL:
Q. Even if you know they're out in the public domain?
MS. PENDERGAST:
A. Absolutely.
MS. BRAZIL:
Q. So is it safe to say, Ms. Pendergast, that that was just your attempt to make sure that

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the legislation was complied with?
MS. PENDERGAST:
A. Absolutely. I mean, when I process ATIPP requests, you know, one of my jobs is to ensure that the integrity of the legislation is being followed at all times, and that again being a mandatory exception, not a discretionary, I--you know, I figured in order to make sure that we are keeping the integrity of that legislation and keeping the information of these individuals private, because that's why the section of the legislation is there, I ensured that those names should be withheld.
MS. BRAZIL:
Q. Right. Okay, Ms. Pendergast, the Commissioner has heard some testimony already with respect to redacting and how matters are redacted or how portions, I guess, are redacted from--or severed from ATIPP requests. What is your practise with respect to that?
MS. PENDERGAST:
A. Well, as the trainer of coordinators in my current role as the manager, and being a previous coordinator myself, when you are

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redacting information on any ATIPP request, we have in the legislation another section that says we have a duty to assist, which means we have a right to tell the applicant if we are redacting any information, why, and for what exception under that legislation that we are redacting it.
MS. BRAZIL:
Q. Right.
MS. PENDERGAST:
A. The practise, and how I train the coordinators across government is that in the margin on the right is where you would sever the information, and then cite the exception under the legislation to show what particular section you are using to withhold this information. The reason being is that if the applicant, once he or she receives the process package when you've concluded your file, is that if they're not happy with that, the recourse is that they can make an appeal to the Privacy Commissioner's Office.
MS. BRAZIL:
Q. Right.
MS. PENDERGAST:

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A. It's my strong understanding that how do they know whether or not they agree or disagree if they don't see the actual exception under the legislation so they can go back to refer to it and --

MS. BRAZIL:

Q. And --

MS. PENDERGAST:

A. And they did want to appeal.

MS. BRAZIL:

Q. Sorry, and the note in the margin, so you note where a portion was severed as well, is that correct?

MS. PENDERGAST:

A. Exactly, yes.

MS. BRAZIL:

Q. Okay.

MS. PENDERGAST:

A. It's either blacked out or it's a big paragraph space, you know, and you would know because right in the margin next to that particular space or that blacked out area, you would annotate your file and indicate what particular exception.

MS. BRAZIL:

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Q. Right, okay.

MS. PENDERGAST:

A. Uh-hm.

MS. BRAZIL:

Q. Now I realize you're back at Justice now, back as manager of the ATIPP office, but you were at Cabinet Secretariat, you're information management, and I guess what we're most concerned about here, you were the ATIPP coordinator for Cabinet Secretariat for about a year and a half, right?

MS. PENDERGAST:

A. Yes, I was.

MS. BRAZIL:

Q. In the course of your year and a half that you spent there, Mr. Pendergast, did you see that the level of Cabinet Secretariat's of the Premier's Office--because, of course, Cabinet Secretariat is the Premier's Department.

MS. PENDERGAST:

A. Uh-hm.

MS. BRAZIL:

Q. Did you see that the level of involvement from Cabinet Secretariat or the Premier's Office was excessive here or unusual?

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MS. PENDERGAST:

A. No, the job of Cabinet Secretariat is to support the premier. The premier is our minister, and, you know, what some people might consider to be an extraordinary involvement on Cabinet Secretariat for ATIPP requests, I considered to be my day to day responsibilities as the ATIPP coordinator for Cabinet Secretariat.

MS. BRAZIL:

Q. Okay.

MS. PENDERGAST:

A. One of my responsibilities was to oversee in the event that I needed to be brought in to consult in certain areas which I already identified. You know, that's something that I considered to be one of my day to day responsibilities. ATIPP coordinators in other line departments in government may not know that, nor do they need to know that. You know, I don't indicate to one department what I'm doing in Health, or I don't indicate to Health what I may be consulting on over in the Department of Justice. You know, it is a responsibility of the ATIPP coordinator at

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Cabinet Secretariat, which is why it varies a little different than the other ATIPP coordinators across government. It's no way excessive. This particular request was handled exactly the same way and was put under the same type of scrutiny and lens that any other request that has hit my desk during the whole year and a half that I had been at Cabinet Secretariat.

MS. BRAZIL:

Q. Now you were--in fairness to you, it was fairly early on in your tenure there that this request came in.

MS. PENDERGAST:

A. It was very early--in fact, I was only there about ten days, yes.

MS. BRAZIL:

Q. But there was nothing unusual or peculiar about this case?

MS. PENDERGAST:

A. No.

MS. BRAZIL:

Q. In comparison to any others that you dealt with since, I guess?

MS. PENDERGAST:

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A. Absolutely. In my year and a half, it was given the same--same attention as any other request that hit my desk after that.

MS. BRAZIL:

Q. Those are my questions for the witness, Commissioner.

THE COMMISSIONER:

Q. Thank you. Mr. Simmons, do you have any questions?

MR. SIMMONS:

Q. I have no questions. Thank you.

THE COMMISSIONER:

Q. Mr. Browne.

MR. BROWNE:

Q. No questions, Commissioner.

THE COMMISSIONER:

Q. Mr. Pritchard--I'm sorry, Mr. Pritchett. One of these days I'm going to start switching the names.

MR. PRITCHETT:

Q. The names are derived from the same root -

THE COMMISSIONER:

Q. I'm sure they are, but my favourite story on that is trying to handle a trial with Mr. McKay and Mr. McKay in the same room, and I

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gave up, but I'm going to keep trying in your case, Mr. Pritchett. Mr. Pike.

MR. PIKE:

Q. Pike is a much more simple name.

THE COMMISSIONER:

Q. Yes.

MR. PIKE:

Q. No questions. Thank you very much.

THE COMMISSIONER:

Q. Mr. Coffey.

COFFEY, Q.C.:

Q. Just so the Commissioner is clear on this, something Ms. Brazil raised with you, Ms. Pendergast. Section 30 --

MS. RENEE PENDERGAST, RE-EXAMINATION BY BERNARD COFFEY, Q.C.

MS. PENDERGAST:

A. Uh-hm.

COFFEY, Q.C.:

Q. When I was asking you, in particular, Sections 18 and 20 are the two that you described would most often cause something to be referred to Cabinet Secretariat's ATIPP office.

MS. PENDERGAST:

A. Yes.

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COFFEY, Q.C.:

Q. Why then would you get involved with a Section 30 in respect of this particular matter that Mr. Coates had referred to you in--I suppose, it was June/July, 2007. Why that?

MS. PENDERGAST:

A. The request was brought to me because Sections 18 and 20 were used, but while I was reviewing those records, I realized that he had not severed out the names, so obviously while I'm going through it, I may very well --

COFFEY, Q.C.:

Q. When you say he hadn't severed out the names, is it true he had not severed out any names or he hadn't severed out a lot of names?

MS. PENDERGAST:

A. He hadn't severed out--I'm not really sure. I can't be confident. I'm thinking any names.

COFFEY, Q.C.:

Q. Okay.

MS. PENDERGAST:

A. At this point, so I had just--you know, while I was going through reviewing the records, I saw that that was the case, and I brought it to his attention while we were discussing the

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other areas of 18 and 20.

COFFEY, Q.C.:

Q. Now in relation to this aspect of the matter, there were no patient names involved here, this wasn't--you weren't seeing patient names that Mr. Coates had omitted to redact?

MS. PENDERGAST:

A. No.

COFFEY, Q.C.:

Q. It wasn't that sort of thing?

MS. PENDERGAST:

A. No.

COFFEY, Q.C.:

Q. If I could, I'm just going to use an example, and I believe I raised this with Mr. Coates who was here, Carl Thompson, do you know who Carl Thompson is?

MS. PENDERGAST:

A. No, I'm sorry.

COFFEY, Q.C.:

Q. Well, the Commissioner as heard, as well as all the lawyers in the room, he's a Judge, he's a member of the Trial Division that sits in St. John's, and, in fact, is the Judge who at one point, anyway, was involved in handling

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the class action lawsuit, okay.
MS. PENDERGAST:
A. Uh-hm.
COFFEY, Q.C.:
Q. After the matter passed through--while the matter was passing through your office, his name was redacted in relation to--in a briefing note, a government briefing note referring to the fact that some matter was-- this particular matter was before him and the status of it at the time, and his name was redacted. Could you tell the Commissioner, please, what the rationale is that would have someone like Judge Thompson's name redacted in these circumstances from a Cabinet briefing note?
MS. PENDERGAST:
A. And I realized that that name was done when we had done our pre-interview, and I can assure Madam Commissioner that that was done in error. His name would have been left in. I'm assuming it was because I really did not know who he was at that time, and I redacted it under those circumstances, but under normal circumstances, if I had realized who he was,

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his name would have been left in.
COFFEY, Q.C.:
Q. Can we actually bring up --
THE COMMISSIONER:
Q. I'm sorry, did I misunderstand what you said earlier. I thought you were saying that even though it might seem frankly silly to some of the rest of us, your interpretation of the legislation was that if the information contained a name which was other than a civil servant presumably conducting their business, that would be deleted. So why wouldn't Justice --
MS. PENDERGAST:
A. Because, I guess, we considered him for him to be a Judge at this point, and his name would be allowed to be left in. He wouldn't be considered to be a--like, would he be affiliated--and I'm not sure if he's a provincial judge or --
THE COMMISSIONER:
Q. No, and believe me, he would not consider himself to be affiliated with the Department of Justice.
MS. PENDERGAST:

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A. Yeah, yeah, so--and I don't know that. That's the reason why chances were his name was released--was withheld.
COFFEY, Q.C.:
Q. And just in relation to that because that was the way when Ms. Brazil was asking about it, you did indicate that, well, if the vetter as it were, in your position --
MS. PENDERGAST:
A. Uh-hm.
COFFEY, Q.C.:
Q. Did not understand that a particular name was that of a civil servant, then the name went?
MS. PENDERGAST:
A. And we would double check some of them if we weren't sure, absolutely.
COFFEY, Q.C.:
Q. But--that's the criteria, if it's not a civil servant --
MS. PENDERGAST:
A. It's withheld.
COFFEY, Q.C.:
Q. Withheld.
MS. PENDERGAST:
A. Uh-hm.

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COFFEY, Q.C.:
Q. And what about--does Section 30 actually say that?
MS. PENDERGAST:
A. I could read you exactly what Section 30 says if you want, just to make sure I have my wording correct. "The head of a public body shall refuse to disclose personal information to an applicant. Subsection 1 does not apply where the applicant is the individual whom the information it relates", and to get to the one regarding remuneration, I'll find that for you now. "The information is about a third party's position, function, or remuneration as an officer, employee, or member of a public body or as a member of a minister's staff". This is the section that we would use to withhold anybody not affiliated with the public service.
COFFEY, Q.C.:
Q. So if I could--just a moment, please. Just a moment, please, Commissioner.
THE COMMISSIONER:
Q. While Mr. Coffey is looking for that, why don't we resolve--I don't know if there is an

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issue. My understanding is that when you were reviewing it, you were reviewing it for whether or not it invoked 18 or 20?

MS. PENDERGAST:

A. Yes, that's correct.

THE COMMISSIONER:

Q. And you said 18 wasn't involved, so it was a question of 20. Were you suggesting that you and Mr. Coates saw 20 the same way or that you recognized that that was a discretion and therefore you accepted that Mr. Coates was free to do what--or at least to recommend to the appropriate official within his department that they do something differently than you would have done?

MS. PENDERGAST:

A. We had a difference of opinion of what to sever under particular documents using Section 20. I think it was -

THE COMMISSIONER:

Q. That was my recollection.

MS. PENDERGAST:

A. Pardon me?

THE COMMISSIONER:

Q. That was my recollection, but I wanted to make

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sure that was your view of the world.

MS. PENDERGAST:

A. Yeah, and that's what it was. We had a difference of opinion how to handle particular documents that he thought should be released and I thought they should be withheld, under the discretionary of Section 20.1(a).

THE COMMISSIONER:

Q. Yes. So that was a case where you expressed your view to Mr. Coates, and did you accept that the Department was free to either accept or reject your view?

MS. PENDERGAST:

A. Absolutely. We can just make recommendations, and as I said, it's at the discretion of the department who was in the receipt of the request to have the final decision on what was going to be released to an applicant.

THE COMMISSIONER:

Q. Okay. So your real problem, in terms of what Mr. Coates did in this case, seems to be--or proposed in this case, was that you seemed to think there is no discretion in respect of Section 13. You would do what lawyers call literally interpreting the legislation?

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MS. PENDERGAST:

A. Absolutely, for Section 30, yes.

COFFEY, Q.C.:

Q. If we could, Exhibit P-0130, page 20. Well, actually, just go back to--if you go back to page one, please, just to put Ms. Pendergast at ease here in terms of this, to put it in context for her. This is what went out to Rob Antle of The Telegram on July 17th, 2007. That's the covering letter, the one from Mr. Wiseman.

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. That would be the, I gather, the request in question or at least--that would be it here?

MS. PENDERGAST:

A. Yes.

COFFEY, Q.C.:

Q. Yes. That you've been speaking about to Ms. Brazil, you were telling her about. If we'd go back, I'm sorry, to page 20, and again, I'll go back, just to put this in context for you. It's a Q & A briefing note. See that? Anticipated questions are all gone. The key

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messages are there. Mr. Coates has told the Commissioner about that. And then on, again, to put it in context for you, this is the March 9th, 2007 briefing note. In here, on the second page of the briefing note, which is page 20 of the exhibit, you go down here to the fourth last bullet, it reads, as it is there now literally, "a claim has been filed named" and the name is redacted "versus Eastern Regional Health Authority, ERHA, with the Government"--I'm sorry, "with the Newfoundland Supreme Court, Trial Division. Government is not named as party to the action." The name is redacted, blank, "is representing the approximately 40 plaintiffs. 'Blank' is representing Eastern Health and 'blank' is assigned as case management judge." When we look at the original, and the Commissioner has seen that elsewhere, that right there is Carl Thompson's name was there.

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. So what--how would that then fall within Section 30?

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MS. PENDERGAST:
A. If that particular judge was a federal judge -
COFFEY, Q.C.:
Q. Yes, he's federally appointed.
MS. PENDERGAST:
A. - we would withhold that name.
COFFEY, Q.C.:
Q. On what basis?
MS. PENDERGAST:
A. On the basis that he's not part of our provincial public service nor is he part of a Minister's staff.
COFFEY, Q.C.:
Q. I'm sorry, could you tell me exactly then, under Section 30, how that gets -
MS. PENDERGAST:
A. 30, if the information is about a third party's position, functions or renumeration as an officer, employee or member of a public body or as a member of a minister's staff.
COFFEY, Q.C.:
Q. So it certainly doesn't involve his remuneration.
MS. PENDERGAST:
A. Um-hm.

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COFFEY, Q.C.:
Q. Which is a matter of public record anyway. And because it identifies Carl Thompson as a case management judge, it's your view that that would then fall within Section 30?
MS. PENDERGAST:
A. Yes.
COFFEY, Q.C.:
Q. Okay.
THE COMMISSIONER:
Q. Do I have it right that a name is considered to be personal information?
MS. PENDERGAST:
A. Absolutely. It's defined under our legislation.
THE COMMISSIONER:
Q. And what you do is you assume that everybody's name comes out unless they fall within the exception under your legislation -
MS. PENDERGAST:
A. Um-hm.
THE COMMISSIONER:
Q. - and that, to your view, essentially narrows it down to people who are either employed by the Government of Newfoundland and Labrador or

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one of its agencies or that long list?
MS. PENDERGAST:
A. Boards or--um-hm.
COFFEY, Q.C.:
Q. And where a provincially--a provincial court judge might be in that, although it's not really germane here, you wouldn't know, I take it?
MS. PENDERGAST:
A. No.
COFFEY, Q.C.:
Q. Okay. That's for another -
MS. PENDERGAST:
A. If it was a provincial court judge, yes.
COFFEY, Q.C.:
Q. - that's for another day. Just in terms of the--Ms. Brazil, and I thank her for this, has canvassed with you the Section 30 issue. Section 18, as you pointed out, didn't come up here or didn't apply here at all. Section 20 dealt with this discretion--application of this discretionary power to exclude, based upon whether it was advice to the Cabinet?
MS. PENDERGAST:
A. Section 18 was advice to Cabinet. Section 18

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would be of Cabinet confidence.
COFFEY, Q.C.:
Q. Oh, I apologize. Advice to a minister, I apologize.
MS. PENDERGAST:
A. Yes, advice for a minister would be.
COFFEY, Q.C.:
Q. Advice to a minister would be Section 20, 20.1(a) and the difference of opinion between yourself and Mr. Coates was that it was your view that all questions in briefing notes should be excluded?
MS. PENDERGAST:
A. The way we view the Q & A notes, I'm assuming is what we are speaking about?
COFFEY, Q.C.:
Q. Yes.
MS. PENDERGAST:
A. Correct me if I'm wrong. We view Q & A notes as on a case by case, line by line basis. We look at them in that context when they become part of the response of records to an ATIPP request, and we review them to see whether or not they do intend to provide advice and recommendations to a Minister, and if they do,

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it is our intent to sever them under Sections 20.1(a)

COFFEY, Q.C.:

Q. And you obtain that information from where?

MS. PENDERGAST:

A. We obtain--well, it's my interpretation as an ATIPP coordinator.

COFFEY, Q.C.:

Q. Well, when you first went to your position at Cabinet Secretariat, did you consult anybody about that? Because this was a point of contention between you and Mr. Coates?

MS. PENDERGAST:

A. Absolutely. We seek some legal advice on it to ensure -

COFFEY, Q.C.:

Q. I don't want to hear anything about your legal advice.

MS. PENDERGAST:

A. No, no, but I just wanted to say that we did seek some legal advice. This wasn't interpretation that I made solely on my own.

COFFEY, Q.C.:

Q. Did you speak to anyone else?

MS. PENDERGAST:

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A. And of course, you know, my executive at Cabinet Secretariat is always consulted on any particular ATIPP request and also, the Premier's office is consulted on certain ATIPP requests.

COFFEY, Q.C.:

Q. And who did you consult about this? Because this is your first -

MS. PENDERGAST:

A. This is my first one. My immediate contact at Cabinet Secretariat was my deputy clerk, which is Sandra Barnes currently, right now, and any discussions I would have with the Premier's Office would have been done with Brian Taylor.

COFFEY, Q.C.:

Q. So you would have canvassed with Ms. Barnes, and I gather Ms. Barnes actually wasn't there at the time.

MS. PENDERGAST:

A. No, she was currently -

COFFEY, Q.C.:

Q. Dorothy French.

MS. PENDERGAST:

A. - on vacation, so Dorothy French was her-- yeah.

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COFFEY, Q.C.:

Q. So you would have spoken to Ms. French about this and Mr. Taylor?

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. And their views were the questions go?

MS. PENDERGAST:

A. They agreed with my interpretation that the questions did indeed reveal recommendations and advice to the Minister, yes.

COFFEY, Q.C.:

Q. And Mr. Coates' view was, and we can look at his e-mails, in fact. The Commissioner has already seen them. His view was that this should be not a blanket approach. It should be varied from case to case.

MS. PENDERGAST:

A. And we don't use it as a blanket approach. We still look at them and we--you know, I respect that 20 is a discretionary exemption and we do look at these on a case by case basis to ensure that they do, in fact, reveal that particular intent of policy, advice and recommendations to a minister.

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COFFEY, Q.C.:

Q. And so this was the first time you had to deal with this in that position?

MS. PENDERGAST:

A. Yes.

COFFEY, Q.C.:

Q. This particular request. Since that time, because Ms. Brazil asked you about, well, what's happened since generally, would you or have you had occasion to consult others about how anticipated questions are to be handled in any subsequent request?

MS. PENDERGAST:

A. No, I haven't had to consult on any subsequent requests, other than this one.

COFFEY, Q.C.:

Q. So you were advised by Mr. Taylor and Ms. French that what? I'm just trying to get, for the Commissioner, the sense of -

MS. PENDERGAST:

A. Well, when I consulted an ATIPP request, let's talk about this one from Health -

COFFEY, Q.C.:

Q. Yes.

MS. PENDERGAST:

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A. When I consulted on this particular ATIPP request, it is through my lens first that I sever--look at the severing of these particular records and I looked at this particular briefing note and I anticipated as well that those questions were indeed, in my opinion, to be advice to the Minister and I bring those then forward to people like, you know, Ms. Barnes or Dorothy French in this one and Mr. Taylor to see whether or not we agree or disagree on my interpretation of how I wanted to handle this particular request.

COFFEY, Q.C.:

Q. And having done so on that one occasion, you haven't had occasion to do so since?

MS. PENDERGAST:

A. No.

COFFEY, Q.C.:

Q. Okay, if we could, and I want to use a concrete example, because we can't see it there on that one. I believe it's P-0126. Just going to go through here just--page five, yes. That's page five. That's the page we were just looking at, just again to make you comfortable, that's Carl Thompson's name

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there.

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. And here, these are the questions that have been redacted obviously on what went out. Are you able to tell the Commissioner why or what it is about any one or more of those four questions that is advice to a minister? How are any one or more of them actually advice to a Minister?

MS. PENDERGAST:

A. When these particular questions are written, they are written in the intent that they are an advice to a minister if they are asked these questions on the floor of the House or things of that nature. So I mean, they may or may not never be asked. They are written with that intent that in the event you're asked a question, these are your potential answers, which you'll see the key messages at the bottom. So just the intent that they are written--certain ones are written with that particular intentions and that's the reason why I considered them in my interpretation to

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be policy advice and recommendations to a minister.

THE COMMISSIONER:

Q. I'm sorry, I didn't quite follow that.

MS. PENDERGAST:

A. They are written--the whole purpose of a Q & A note is to provide guidance to ministers on potential questions that they may or may not be asked and when they are written, they're written with that intention and when I look at those, I see those that, you know, these are written with that intention, to be advice to the minister.

THE COMMISSIONER:

Q. So wouldn't every question do that then?

MS. PENDERGAST:

A. No, not every question may do that, and that's why we look at them on a case by case basis. You know, there's -

THE COMMISSIONER:

Q. Well, what kind of question would not be falling into that?

MS. PENDERGAST:

A. If I had to think of one off the top of my head, I mean, if somebody asked--if one the

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anticipated questions was to a justice--to the Justice Minister, "was the ATIPPA Act proclaimed in January of 2005?" That, to me, would be a factual type question and under our legislation, we reveal those types of questions. So that particular question wouldn't be severed under a Q & A note, but I consider these ones to be strictly that, advice and recommendations to the minister.

THE COMMISSIONER:

Q. So "when will breast cancer screening tests resume at the laboratory in St. John's?" is not a factual question?

MS. PENDERGAST:

A. Not in my interpretation, no.

THE COMMISSIONER:

Q. And it's--and once again, it is advice to a minister--other than the fact that somebody is saying to him "this might be asked to you" how is it advice?

MS. PENDERGAST:

A. Because it may or may not be asked. It's a recommendation of these may be questions you may be asked. So that, in our interpretation, makes it just that, advice and recommendations

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to a minister.
THE COMMISSIONER:
Q. Okay, so what raises the spectre of it being advice to the minister is that you may or may not be asked this question.
MS. PENDERGAST:
A. Um-hm.
THE COMMISSIONER:
Q. But if you're asked a question, example you gave was that if you asked a question which requires a factual answer, you can give that?
MS. PENDERGAST:
A. Yes.
THE COMMISSIONER:
Q. But when will breast cancer screening tests resume at a laboratory is not a factual question, and you therefore can't give that? Why is it not a factual question? It's asking a person a question which requires an answer of a particular time or "I don't know the answer" but it seems to me what is being asked is a fact, not an opinion.
MS. PENDERGAST:
A. That one may very well be. I guess when I look at them, I look at what their intentions

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were when they were written, and these, particularly in my opinion, were written with that intent and that's the reason why I severed them under Section 20.
THE COMMISSIONER:
Q. The intent being to advise a minister of the kind of question he's likely -
MS. PENDERGAST:
A. He or she may be asked, yes.
THE COMMISSIONER:
Q. Yes, okay. Well, on that logic, it seems to me that all questions should go in there.
MS. PENDERGAST:
A. And to date, Madam Commissioner, if I may say that, right now, we haven't come across any that we have left in, because the ones that we've seen so far to date have been, in our interpretation, to be advice and recommendations to a minister for that reason.
THE COMMISSIONER:
Q. Because somebody is saying "Minister, this is a question that you might get"?
MS. PENDERGAST:
A. Um-hm.
THE COMMISSIONER:

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Q. And that's advice to a minister.
MS. PENDERGAST:
A. Um-hm.
THE COMMISSIONER:
Q. Okay.
COFFEY, Q.C.:
Q. I have just one final question, if I could, Commissioner. Ms. Pendergast, can you tell the Commissioner or explain to the Commissioner then how key messages differ from anticipated questions?
MS. PENDERGAST:
A. The key messages, or the answers, which we like to call them -
COFFEY, Q.C.:
Q. They're suggested answers.
MS. PENDERGAST:
A. The suggested answers, are--a lot of them are facts and under our legislation of 20.1(a) or 2(a), it says that factual information must be released under ATIPPA. So when I look at this, and I'll scroll down, if you don't mind, when I look at what was here, when I did my run through of this particular document, I saw the information here to be factual type

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information and under the ATIPPA legislation, I felt that we need to disclose that. So that's my different--that's the difference in taking out the questions, but leaving in the key messages or the answers. That's our rationale.
COFFEY, Q.C.:
Q. I appreciate--so what is it then that's different--other than your assertion that it is factual, and as the Commissioner was pointing out to you, perhaps the second question under anticipated questions is factual there, because it demands -
THE COMMISSIONER:
Q. Or requires a factual answer.
COFFEY, Q.C.:
Q. Factual answer, requires a factual answer, and in fact, if you look at the second last key message, one with note that the answer is there, "Eastern Health resumed ER/PR testing in St. John's on February 1st, 2007."
MS. PENDERGAST:
A. Um-hm.
COFFEY, Q.C.:
Q. So that would be factual. The difference

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between anticipated questions and key messages can't be distinguished on the basis of whether or not they may or may not be asked or answered because you don't know. The people who draft this don't know if the minister is ever going to be asked those questions, right?

MS. PENDERGAST:

A. Um-hm. Well, that's their intention, to -

COFFEY, Q.C.:

Q. So these are suggested answers, correct?

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. Some of them may or may not be factual, depending upon the circumstances?

MS. PENDERGAST:

A. Um-hm.

COFFEY, Q.C.:

Q. And I could take you through this and some of this is factual, some of it's opinion, okay, in the key messages. And certainly then, the key messages are the advice of whoever drafted this to the Minister as to how to answer this question?

MS. PENDERGAST:

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A. A lot of the answers are factual type answers, which is why the key messages are left in. It's the fact that the anticipated questions are written with the advice "you may be asked these questions" is what we look at when we decided to withhold them. So that is our rationale when we look at this--we looked at this document.

COFFEY, Q.C.:

Q. And so you think, for example, the third key message there "Eastern Health's first priority was its patients," you think that's a factual assertion or is it a matter of opinion?

MS. PENDERGAST:

A. I can't say, because I'm not the author of this particular document, Mr. Coffey, so I don't know if I could -

COFFEY, Q.C.:

Q. Thank you, Commissioner.

THE COMMISSIONER:

Q. Now, do you have anything arising, Ms. Brazil?

MS. RENEE PENDERGAST, EXAMINATION BY MS. JACQUELINE BRAZIL

MS. BRAZIL:

Q. Just a couple of quick questions,

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Commissioner. Now Ms. Pendergast, Mr. Coffey asked you about this particular ATIPP request. He said that you consulted--you confirmed for him that you consulted Mr. Taylor and Ms. French within Cabinet Secretariat and the Premier's Office? Is that correct?

MS. PENDERGAST:

A. Yes.

MS. BRAZIL:

Q. Now you also said though that you sought a legal opinion about whether--now we don't want you to tell what that legal opinion was, but you sought a legal opinion about this particular ATIPP request as well, right?

MS. PENDERGAST:

A. Yes, we did.

MS. BRAZIL:

Q. And then you were asked a question, did you ever seek their opinion on this type of question after the fact. Is that--and you said that you didn't.

MS. PENDERGAST:

A. Um-hm.

MS. BRAZIL:

Q. And is that because you felt you clarified it

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this time around?

MS. PENDERGAST:

A. Absolutely. I mean, when we seek a legal opinion on a point of this legislation, I mean, we continue to use those legal opinions. So that, you know, we figured we had already accepted the legal opinion on this particular note, so that opinion could be used for any future notes that we may have come across.

MS. BRAZIL:

Q. Right, and you also clarified that once you understood that Justice Thompson was not a public servant, within the legislation that you still believe his name should have been redacted?

MS. PENDERGAST:

A. Yes. When I saw his name originally in the document, I apologize, but I did not know who he was. So when I do any type of severing, even consulting, as I did on this particular request, I just took out his name, just as a safety precaution, right there and then. If the department comes back and says to me, "no, we know who he is" or he is, you know, an affiliate of one of our public agencies and

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that, then we will put the name back in.

MS. BRAZIL:

Q. Right.

MS. PENDERGAST:

A. In this case, because he was a federal counterpart, then we still removed those names.

MS. BRAZIL:

Q. Okay. So you'd remove the name of a Federal civil servant too obviously?

MS. PENDERGAST:

A. Absolutely.

MS. BRAZIL:

Q. Yes, okay. Now Mr. Coffey asked you the question about why--your primary involvement here is with Section 18 and Section 20, of course.

MS. PENDERGAST:

A. Yes.

MS. BRAZIL:

Q. And Mr. Coffey asked you why you were concerned about Section 30, and would you say that that really is probably--I don't know if hangover is the right word, but just sort of carrying forward what you had done in your

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previous--well, in your present job really?

MS. PENDERGAST:

A. Absolutely, yes, because I trained the coordinators in how to properly process ATIPP requests and knowing that, you know, Section 30 is one of our strong mandatory discretions and exceptions in this legislation, then you know, as I was going through the document, I guess, knowing what I know in my role as the manager of the ATIPP office, I knew that, you know, practice is that we do not leave those names in, and although I respect Reg's, you know, rationale that they are already out there in the public domain, unfortunately when I train coordinators, I don't tell coordinators to go out and look in the public domain and look on the web or the newspapers or anything to see whether or not people's names are out there. I tell them to strictly focus on the legislative lens and abide by the exceptions that we have to use under this legislation, in order to keep the integrity of the legislation intact.

MS. BRAZIL:

Q. Okay. So despite the fact that your primary

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involvement here as ATIPP coordinator for Cabinet Secretariat was to address, you know, questions around Section 18 and Section 20, because of your other job, you had no trouble weighing in on that point?

MS. PENDERGAST:

A. Absolutely not.

MS. BRAZIL:

Q. Is that a fair -

MS. PENDERGAST:

A. Absolutely, and I would that to anything else I may come across with any coordinators while I'm reviewing documents for 18 and 20, if I find anything else that may jump out at me, that you know, I may want to bring it to their attention, you know, "did you think about this?" Because I mean, human error kicks in. They may have not--they may have missed it along the way and then we can get into a discussion, and again, it's at their discretion whether or not they want to follow our recommendations.

MS. BRAZIL:

Q. All right. Those are my questions, Commissioner.

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THE COMMISSIONER:

Q. Thank you, Ms. Brazil. Since most of that came up with questioning of Mr. Coffey and Ms. Brazil, and we'd sort of gone around the room before a lot of that information came out, I just want to make sure that nothing arose there which gives any other counsel rise to a question, and sort of speak now or hold your peace time.

MR. SIMMONS:

Q. No, Commissioner.

MR. BROWNE:

Q. Nothing, Commissioner.

THE COMMISSIONER:

Q. All right, thank you very much. Thank you, Ms. Brazil. And we're a little later than usual, so 20 after two.

(BREAK)

THE COMMISSIONER:

Q. Please be seated. Mr. Coffey.

COFFEY, Q.C.:

Q. Commissioner, the next witness is a returning, is Dr. Cathi Bradbury.

THE COMMISSIONER:

Q. Welcome back, Dr. Bradbury.

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DR. BRADBURY:
A. Thank you.
THE COMMISSIONER:
Q. Take a seat.
DR. CATHI BRADBURY, RESUMES STAND, EXAMINATION BY BERNARD COFFEY, Q.C. (CONT'D)
COFFEY, Q.C.:
Q. Now, Dr. Bradbury, of course, it's been some time since you testified. I had been about to embark upon asking you some questions about May 24th, 2007 and that period. Now in relation to that, we understand the Commission has heard, both before you testified and since, that on May 15th, 2007, this matter was raised publicly on CBC media reports and in the House of Assembly and it has continued on from there. Doctor, in terms of ER and PR, and I take it as a physician you would have understood estrogen and progesterone, would have heard of it before.
DR. BRADBURY:
A. Yes, I had.
COFFEY, Q.C.:
Q. In relation to what we've called the ER/PR matter, when did you first become aware of

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that?
DR. BRADBURY:
A. From a formal point of view, the first discussions that I had was at a VP of Medicine meeting late September 2005.
COFFEY, Q.C.:
Q. Okay, and would you tell the Commissioner about that? I'm going to kind of take you through that part of it and right up to May of '07.
DR. BRADBURY:
A. Right. Several senior administrative people, including myself, meet regularly with the VPs of Medical Services that are in each of the RHAs, and the NLHBA, which is the Hospital Board Association, serves as a secretariat to that. We meet every month or every two months and Bob Williams presented the issue of ER/PR as an agenda item for the first time, to my knowledge, at the September 2005 meeting.
COFFEY, Q.C.:
Q. And what did he--what do you recall him telling you about it?
DR. BRADBURY:
A. I don't recall the specifics of that meeting

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because subsequently we--it was more or less sort of a standing agenda item that he would periodically update the members of the committee, but he certainly alluded to the fact that there were problems identified with some of the results of the ER/PR testing at Eastern Health. Other than that, I don't recall any other details.
COFFEY, Q.C.:
Q. And I take it in the context there, why would he be telling the committee that?
DR. BRADBURY:
A. He would have told the committee because Eastern Health is the only facility in Newfoundland that was doing the ER/PR testing, and so patients who had testing done would have been from the RHAs all over the province. So the VPs of Medicine would certainly want to be involved and updated as to what the issue was and how it was being addressed.
COFFEY, Q.C.:
Q. And from your perspective, did you then, having heard this, did you go back and speak to anybody at the Department about it?
DR. BRADBURY:

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A. I would have had discussions with my line boss at the time, Dr. Ed Hunt, but other than sort of within our own division or with Ed, no.
COFFEY, Q.C.:
Q. And do you recall Dr. Hunt's reaction?
DR. BRADBURY:
A. No, I don't.
COFFEY, Q.C.:
Q. Okay, and was anything, at that time, having discussed the matter with him, was there anything further expected of you at that time, in relation to that matter?
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. In terms of ER/PR then, the next--and I appreciate then--well, I'll just ask you, this committee meeting, which I take it was a relatively regular meeting?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Did this come up from time to time?
DR. BRADBURY:
A. Yes, it did.

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COFFEY, Q.C.:
Q. And it was raised by?
DR. BRADBURY:
A. Typically Dr. Williams would speak to, you know, what the status of the testing was. I do recall he spent one meeting sort of just describing some of the issues around sort of the actual test itself and, you know, some of the difficulties encountered and then, as I said, would otherwise then sort of provide regular updates as to, you know, the timing of the reports coming back from Mount Sinai, you know, those type things.
COFFEY, Q.C.:
Q. And then as these update briefings occurred from time to time at the committee, would you pass them on to anyone?
DR. BRADBURY:
A. No. Again, typically Dr. Hunt would attend those meetings with me.
COFFEY, Q.C.:
Q. Okay.
DR. BRADBURY:
A. And Dr. Hunt then, again, as part of sort of the regular administrative process, would be

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attending executive meetings within the Department on a regular basis and it would be up to him essentially to, you know, report on those things that he thought needed to be brought to the attention of the executive.
COFFEY, Q.C.:
Q. Which would be the other ADMs, because he was, in effect, an ADM at the time, Dr. Hunt?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. And the DM?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. And the Minister, if he was there. What then, other than these periodic meetings--did you have any other--and I gather, as a member of the public, you would have seen it referred to in the media from time to time.
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Beginning in the fall of 2005. Did you have any further involvement yourself directly in

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it?
DR. BRADBURY:
A. Directly with the ER/PR issue?
COFFEY, Q.C.:
Q. Yes.
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. As time--we go through '05, all the way through '06, we're into 2007, and there was no--other than occasionally you being the beneficiary of an ad hoc briefing, you had no other involvement?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. What then happened in 2007?
DR. BRADBURY:
A. We're into May of 2007 and I was copied on an e-mail that had been sent out by our Deputy Minister of the day. I don't recall the exact date, May 21st, May 22nd. And he had requested that a teleconference be arranged between the Department and the VPs of Medicine and a pathology representative from each of

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the four RHAs and then there was a little sort of PS on the bottom of the e-mail where he asked that Moira Hennessey, the ADM of Board Services, and myself attend the teleconference.
COFFEY, Q.C.:
Q. P-0854, please?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. That would be it, I take it, and that's the e-mail you're referring to, one of May 23rd, 2007?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. And it says "please call me on my cell." It's from John Abbott to Oscar Howell, and "please call me." Urgent is the subject and the text says "please call me on my cell. Also need for you to arrange a conference call tomorrow a.m. with other VPs of Medical Services in province on ER/PR issue and current testing process" and it's "processes, as well. Please include Cathi Bradbury and Moira Hennessey in

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the call," and it's copied, as you point out, to--there you are, yourself and Ms. Hennessey. Did you have any heads up that you were going to get this sort of an e-mail?

DR. BRADBURY:

A. No.

COFFEY, Q.C.:

Q. Because you had not been copied, I take it, on any earlier e-mails relating to this?

DR. BRADBURY:

A. Correct.

COFFEY, Q.C.:

Q. Did you make any inquiries about, "well, why am I receiving this now?"

DR. BRADBURY:

A. At the time, no.

COFFEY, Q.C.:

Q. Okay. Did you have any understanding about why you were receiving it? Make any assumptions about it?

DR. BRADBURY:

A. I had understood that questions or issues had arisen in the House that day during Question Period and that there were some misunderstanding as to what the current status

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of ER/PR testing in the province was.

COFFEY, Q.C.:

Q. And why would you be copied on this now?

DR. BRADBURY:

A. I can't tell you for absolute certainty. Dr. Hunt could have been away.

COFFEY, Q.C.:

Q. Okay.

DR. BRADBURY:

A. Or specifically John, you know, could have requested that I attend the meeting.

COFFEY, Q.C.:

Q. Prior to this, do you have any recollection of discussing the ER/PR matter with John Abbott at all?

DR. BRADBURY:

A. No.

COFFEY, Q.C.:

Q. How about with Moira Hennessey, that you can recall?

DR. BRADBURY:

A. Not that I can recall.

COFFEY, Q.C.:

Q. What then happened?

DR. BRADBURY:

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A. Pardon?

COFFEY, Q.C.:

Q. What then happened?

DR. BRADBURY:

A. We had a teleconference arranged for the following morning, which is now May 24th, and it was attended by the VPs of Medicine. There was a pathologist from each of the four RHAs present on the teleconference as well, myself and Moira, and John Abbott and I don't recall if there was anyone else from the Department or not.

COFFEY, Q.C.:

Q. What happened then? So what was your role, first of all, in it, going into this conference call involving numerous parties in numerous places? What was your understanding of your role?

DR. BRADBURY:

A. The direction that I had received at the time was that there were certain questions either in follow up or as part of the previous day's conversation in the house, that there were several additional questions that were anticipated to be asked in that afternoon's

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session of question period in the house, and so I was asked to be the primary author for a sort of a briefing note for question and answer period.

COFFEY, Q.C.:

Q. And who asked you to do that?

DR. BRADBURY:

A. I assume it was John.

COFFEY, Q.C.:

Q. Mr. Abbott?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Then I take it you did so?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. And I ask, perhaps, that exhibits, and I hope I have the right exhibit numbers, P-1724 brought up? You recognize the handwriting?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Whose is that? Whose is that?

DR. BRADBURY:

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A. It would be mine.
COFFEY, Q.C.:
Q. Okay. And while we're on it, and I'll come back to this in a moment, P-1725, please? Do you recognize the handwriting in this?
DR. BRADBURY:
A. Yes. That's the handwriting of Dr. Blair Fleming, who is the assistant medical director in the physician services division.
COFFEY, Q.C.:
Q. Okay. And to your knowledge how, if at all, was Dr. Fleming involved in this?
DR. BRADBURY:
A. These notes were taken approximately a week, a week to ten days after the notes that we just looked at and during that period of time, which was early June, 2007 I was away.
COFFEY, Q.C.:
Q. Okay, and we'll come to that because we have notes. If we could just look, please, at P-1723? These would be your notes of June 1st, 2007?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:

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Q. Okay. And so that there'd be the ones we first looked at first, P-1724, is that May 24th conference call. 1723 are your notes of June 1. We'll come to that. And then while you were away Dr. Fleming was involved?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Okay. If we could go then, please, to 1724? And, Doctor, there are actually 11 pages in the exhibit itself. Flip through them now and have you look at them. See the number four there in top left-hand side?
DR. BRADBURY:
A. Um-hm.
COFFEY, Q.C.:
Q. Five, six, seven, and then there's another one with kind of a list, one, two, three, and some other points. And then there's one with a number of columns. There's a name and the--Heather is there, Terry Gulliver and Heather, page nine of the exhibit. And then page ten there's some handwriting of yours and page 11, as well. Now, Doctor, these notes then relate to, I take it, first of all, certainly, the

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May 24th, 2007 conference call?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Do they relate to anything else?
DR. BRADBURY:
A. You'll notice that the numbers are not consecutive. The first six or seven pages were the notes that I took when the entire group of people that we previously discussed were attending the teleconference. And then from what I recall -
COFFEY, Q.C.:
Q. Okay, I'm just going to go back just so the Commissioner can follow that. That would be back as far as page seven of the exhibit, if we go back, if we look at six?
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. Five, four and so on?
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. So from one to seven on the--one is not

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numbered, but two, three, four, five, six, seven were your notes made during the conference call involving the whole group?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. Okay, go ahead.
DR. BRADBURY:
A. Okay. And then if you go to the next page?
COFFEY, Q.C.:
Q. Yes, that's page eight of the exhibit?
DR. BRADBURY:
A. Right. Sort of at the end of that everyone sort of participating in the conference call sort of agreed that the focus of the briefing note then would look at sort of, you know, the history of ER/PR testing as well as what the current status was in the province, what sort of were the plans for Eastern Health to provide ER/PR services on a go-forward basis and then some discussion about sort of what were, if any, the specific problems identified and if there was anything that was region specific. And then so that would be the focus of the, you know, sort of the answers given in

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the briefing note. And then if you continue on then.

COFFEY, Q.C.:

Q. Yes, page nine?

DR. BRADBURY:

A. Pages nine, ten, and eleven would be the conversation then that I had with the smaller group involving primarily the pathologists. And I don't recall whether the VPs of medicine stayed on for that section of the conversation or not.

COFFEY, Q.C.:

Q. The people, the technical people?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Were involved in the second part of the teleconference?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. And maybe the VPs?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

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Q. Of medicine.

DR. BRADBURY:

A. And then there's the other document and that's just the one page here with a lot of numbers on it.

COFFEY, Q.C.:

Q. Okay.

DR. BRADBURY:

A. I'm not sure which one of the -

COFFEY, Q.C.:

Q. Just want locate that for you. There's 1723.

DR. BRADBURY:

A. So this was just sort of a one-page note that I took in a subsequent phone call that I made to Heather Predham on June 1st.

COFFEY, Q.C.:

Q. June 1st, I had understood that. And we'll come to that.

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. And then, of course, and I hope then through you to at least address some of the matters referred to in the notes we looked at from Dr. Fleming.

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DR. BRADBURY:

A. Okay.

COFFEY, Q.C.:

Q. If we go back then to 1724, go back to page one, please? Now, Doctor, again, to help the Commissioner put this in perspective, I take it that in terms of ER/PR, well, you would have known what a physician of your background would know about ER/PR just generally, and I suspect it's relatively little compared to an oncologist or pathologist. You would have know that before you ever heard of this matter, what Dr. Williams had said from time to time and what you'd heard in the public media?

DR. BRADBURY:

A. Correct.

COFFEY, Q.C.:

Q. Okay, and then you're tasked then with, in effect, I take it, coordinating this teleconference?

DR. BRADBURY:

A. Correct.

COFFEY, Q.C.:

Q. Managing it. Could you then, if it would be

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of assistance, I want you to take us through, then, what your notes indicate and what you can recall otherwise, perhaps, about how that teleconference unfolded?

DR. BRADBURY:

A. Okay. Certainly the first part of the teleconference and the notes sort of confirms this, was addressing the question of where on that particular date, sort of in May, 2007, at what sites ER/PR testing--well, let me rephrase that. Not as to where it's being done but what patient samples were being done. And the information that we received at the time was that ER/PR testing had resumed in the province, it had ceased in late 2005, it had been resumed February, 2007, but it was resumed--what it says there is that St. John's site only, but what I mean there the St. John's samples only were being done at the St. John's site. And then samples from other sites outside of St. John's were continuing to be referred to Mount Sinai for interpretation. And that was--so the note then goes on to talk about Terry Gulliver sort of reconfirmed so that was specimens from -

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COFFEY, Q.C.:
Q. St. John's hospitals.
DR. BRADBURY:
A. St. John's hospitals only. He made a comment then about sort of the validation and quality assurance, they were getting good results. The next note says "Corner Brook, Gander and Grand Falls going directly to Mount Sinai." And then there's a comment here, you know, the conversation expanded then beyond sort of just the ER/PR testing, recognizing that there was another test that could or should be done called HER2/neu. And 18 months previous, so we're, you know, back into 2005, they would have just been doing ER and PR testing on breast samples, but now the standard was as the initial screen would include ER/PR as well as HER2/neu. And as of May, 2007 HER2/neu samples from the entire province were going to Mount Sinai for interpretation. And so the next comment goes on to say, again, just sort of redescribes that every patient diagnosed with breast cancer today was having ER/PR, HER2/neu and that there were roughly 300 to 350 cases of breast cancer diagnosed each year

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in the province.
COFFEY, Q.C.:
Q. Okay.
DR. BRADBURY:
A. To help put it in context. We spent a little time then sort of talking about the HER2/neu test. And the HER2/neu, similar to ER/PR, is a test to determine whether a patient should be considered for Herceptin, sort of another chemotherapy agent for patients, as I understand it, who have metastatic disease. And the information that we received was that at the time St. John's sort of had been making changes for the reintroduction of the ER/PR testing in early '07, that the antibody test for the HER2/neu had changed and that they couldn't offer the test while they were sort of in the process of validating their new ER/PR process. And then someone made the comment that despite their inability to offer this new test, that Mount Sinai had expressed their desire for St. John's to take over ER/PR testing for the entire province as soon as they were able to do it. It then goes on to describe that the antibody, and again, this is

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relation to the HER2/neu test, is that the antibody had been ordered. The plan at that point in time was to sort of validate it over the summer of 2007 and then to start to do the HER2/neu test in the late summer, 2007.
COFFEY, Q.C.:
Q. So this portion of it relates to the antibody for the HER2/neu?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. And doing HER2/neu in St. John's?
DR. BRADBURY:
A. That's right.
COFFEY, Q.C.:
Q. That part of it.
DR. BRADBURY:
A. So that--that was sort of the general discussion that we had about the status of testing in the province, and then the conversation turned to fixation, and someone had identified that there was working being done on a new provincial package about how the tissues needed to be handled or prepared in advance of them being sent to St. John's, and

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--so specifically having to do with the fixation process, and I just made a note there that fixation prevents tissue destruction, but can impact on the receptors that are involved in ER/PR testing, and that specifically particularly as it applied to immunohistochemistry, you can get false negative results if the fixation of the specimen is not properly performed. Then, you know, go on to say that the fixation policy has been drafted, sent out to other laboratories, and like I said, specifically then to do with specimens to be sent to St. John's and just a couple of general comments about the length of time it was recommended that specimens be exposed to the formalin, and then sort of a range, as well as a maximum period of time that a specimen should be fixed before it's grossed and processed.
COFFEY, Q.C.:
Q. You've made a note here, your handwriting, "Exposed to formalin for 30 minutes", and it says, "Fixed, six to eight hours, maximum 24 hours". So this presumably would have been some pathologist?

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DR. BRADBURY:
A. Someone must have made comments about some of the details about the fixation policy. It wasn't presented during this teleconference, but these would have been comments that I would have recorded from someone describing some of the details in the policy.
COFFEY, Q.C.:
Q. Describing them during the teleconference or during the second part of the teleconference?
DR. BRADBURY:
A. It would have been during the general teleconference.
COFFEY, Q.C.:
Q. The general teleconference, okay, and then --
DR. BRADBURY:
A. Okay, and so then the next part of the teleconference sort of focused on now that sort of ER/PR testing had at least resumed for St. John's samples, then some description as to what some of the validation and the quality assurance policies and procedures that had been brought in. So this was sort of on a-- to proceed or on a go forward basis, they identified that over the past year they had

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been sending some of the specimens out to other international sites, and so, you know, getting sort of a second read or a second opinion as to the diagnosis and stuff, to look at accuracy of reporting, and then--this obviously relates to the actual date then that reopened the testing.
COFFEY, Q.C.:
Q. It reads here, "Reopened the testing for ER/PR as of February 1st for the province".
DR. BRADBURY:
A. I would assume that would have been February of this year because this was on--sort of on a go forward basis, and then--so we had those sort of three topics talked about in general, and then we decided to have a little bit of a conversation then, sort of region by region, site by site, and just to sort of confirm what was happening within the different RHA's, and --okay, someone, I assume from Eastern Health, made the comment that while ER/PR testing was not being done for all of the province, that anticipated that that could perhaps change over the next month or so.
COFFEY, Q.C.:

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Q. In fact, take over ER/PR for all of the province in the next month is what the note-- the asterisk, the notes says?
DR. BRADBURY:
A. Yes, that was the expectation at the time, and then that, however, would be distinct from the HER2/neu where St. John's was still at that point in time not able to do the testing for the HER2/neu, so what they were suggesting is that the samples would still come in to St. John's, and that all of the blocks then--so once things were grossed and processed, all of the blocks for the province would go from St. John's to Mount Sinai.
COFFEY, Q.C.:
Q. I take it then that beginning in the next month in that time, back in May of 2007, someone from Eastern Health was suggesting or offering that within a month or so St. John's could take over doing the testing for all ER/PR for the province?
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. By sending the blocks in to St. John's and

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then after St. John's had done the ER/PR test, St. John's would, as it had already been doing for its own blocks, sending them all on to Mount Sinai for HER2/neu?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Okay.
DR. BRADBURY:
A. The other thing that was discussed as well, and this was sort of a part of as we proceed or into the future, one of the--one of the proposals that Nash Denic sort of discussed and felt very strongly about was particularly for carcinoma in-situ specimens, say, where lymph nodes were negative, that not only, say, would there be sort of a limited group of physicians who would do the review, but there would also be a secondary review as well, both to confirm--to confirm the diagnosis.
COFFEY, Q.C.:
Q. And that would be confirm a diagnosis of carcinoma in-situ?
DR. BRADBURY:
A. Yes.

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COFFEY, Q.C.:
Q. And to confirm any diagnosis that the lymph nodes were negative?
DR. BRADBURY:
A. Well, typically in a situation of carcinoma in-situ, you would anticipate the lymph nodes would be negative.
COFFEY, Q.C.:
Q. Yes.
DR. BRADBURY:
A. But--yeah. So this would be a change in that so there would be a second read of all cases of breast cancer diagnosis.
COFFEY, Q.C.:
Q. And you recall it was Nash Denic who was--Dr. Denic who was producing this?
DR. BRADBURY:
A. Yes, he spoke--he spoke very--he spoke strongly to this.
COFFEY, Q.C.:
Q. Did he explain why?
DR. BRADBURY:
A. I think he felt that it--that it was important to, say, from a quality assurance point of view, particularly for the carcinoma in-situ

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where, you know, there may either be difficulty in diagnosis or difficulty in staging, but particularly for this group, felt that sort of a second opinion or a second read on it should be a significant part of their quality assurance program.
COFFEY, Q.C.:
Q. Do you recall what, if anything, was the reaction to that? Was there any reaction expressed that you recall?
DR. BRADBURY:
A. Not that I recall.
COFFEY, Q.C.:
Q. Okay, go ahead, Doctor.
DR. BRADBURY:
A. Okay. So then we get into the process here. So what I then go on to describe is what was happening in that specimens were being fixed, for example, in Gander, and were being processed in St. John's, but the interpretation, reading, and reporting was happening in Gander.
COFFEY, Q.C.:
Q. Okay.
DR. BRADBURY:

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A. So the specimens in the recent past were following this model.
COFFEY, Q.C.:
Q. Gander, St. John's --
DR. BRADBURY:
A. And then back to Gander. That was given sort of just as an example.
COFFEY, Q.C.:
Q. Sure.
DR. BRADBURY:
A. You know, this was applicable to if it was Grand Falls, if it was Corner Brook. So any site that it was being referred to was being sent to St. John's for process, but the reading and interpretation and reporting was happening regionally. The proposal then that was being discussed was that a specimen that would come from a regional site would --
COFFEY, Q.C.:
Q. The example here is Gander, I take it.
DR. BRADBURY:
A. Was Gander, was that a specimen would now come to St. John's as before for processing, but that the reading, interpretation, and reporting would occur in St. John's. So this

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would certainly be a change sort of in the reporting process.
COFFEY, Q.C.:
Q. Now here it's difficult to see it here, it's slightly cut off--you probably have the originals, do you?
DR. BRADBURY:
A. I do--I don't have the original, I just have a photocopy, and it's unfortunately cut off here again.
COFFEY, Q.C.:
Q. "The external reviewers, it was an issue, fixation".
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. "Fixation problem. External reviewers, it was an issue".
DR. BRADBURY:
A. Yes, I would agree that that appears to be the correct interpretation.
COFFEY, Q.C.:
Q. Do you recall what that was about?
DR. BRADBURY:
A. There was clearly a lengthy discussion about

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fixation and while this sort of section talks about the reporting, on the previous page it talked about, you know, the false--the false negatives, and so at some point in time someone had asked the question about whether sort of fixation had been determined to be one of the problems as part of the external review process that Eastern Health had gone--had undertaken, and I had written here that external reviewers, yes, it was a problem. So as I described previously then, we're now sort of doing the region by region review. This, if I recall, was Dr.--I believe it was Dr. Gaulton.

COFFEY, Q.C.:

Q. Dalton?

DR. BRADBURY:

A. Yes, Dr. Dalton from Grand Falls. I don't think it was Dr. Gallagher, and he made the statement that all breast cancers that are questionable in their region were already being sort of sent in to Dr. Bev Carter for a second read or sort of for confirmation of diagnosis.

COFFEY, Q.C.:

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Q. For example, whether it's DCIS, carcinoma in-situ versus invasive?

DR. BRADBURY:

A. Correct.

COFFEY, Q.C.:

Q. That was that issue?

DR. BRADBURY:

A. Yes, okay, and then this question came up about what is Mount Sinai saying about the quality of the samples, and Dr. Dalton--I guess it is Dr. Dalton, confirmed that they were using the St. John's protocol with regards to fixation and he reconfirmed that they will continue to follow the protocol for fixation.

COFFEY, Q.C.:

Q. This is now using St. John's protocol, 8 hours/24 hours?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. And you have noted here, "Dr. Dalton will follow the protocol for fixation".

COFFEY, Q.C.:

Q. Okay, and then we had a general--it looks like

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then there was some general commentary about immunohistochemistry where--and the impression I had was that it wasn't specific to immunohistochemistry, but that sort of the general thinking sort of for pathology specimens, the more fixed a specimen was, which essentially sort of stabilizes the specimen, then the better the specimen was. The point was made, however, that specific to immunohistochemistry testing, that if it's over fixed or if it stays in the fixation liquids too long, it actually kills or reduces the antigen site, and then just sort of made the general comment that immunohistochemistry is done through antibody staining techniques. So if you don't have any antigen, then, of course, the antibodies won't stain and then you'll end up with false negatives.

COFFEY, Q.C.:

Q. Do you recall who made that statement?

DR. BRADBURY:

A. No.

COFFEY, Q.C.:

Q. So who was--who was offering, or what class or group of people was offering comments about

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this?

DR. BRADBURY:

A. It would have been all of the pathologists--as I said, there would have been pathologists from all regions, and I don't know who would have made this statement.

COFFEY, Q.C.:

Q. The reference to, "If over fixed", you've noted it as "kill the antigen site", and you've got an indicator here, "not common knowledge ten years ago".

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. So I take it some one or more of the pathologists was expressing the opinion or view that this assertion about over fixation was not common knowledge?

DR. BRADBURY:

A. Yes, okay.

COFFEY, Q.C.:

Q. But you can't recall who was making this assertion?

DR. BRADBURY:

A. No, I don't. So then the question presumably

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was asked was whether this issue of over fixation or whether this was sort of known prior to the review process. So someone asked the question, did we ever identify there were fixation issues either inside or outside St. John's, and someone alluded to commentary in 2005. I put a question mark there because I clearly didn't sort of fully appreciate someone making note of 2005. I assume at this point in time it's probably in reference to the external reviews that were done.

COFFEY, Q.C.:

Q. Okay.

DR. BRADBURY:

A. So we're still talking about fixation and someone asked the question whether or not there's a national standard for fixation, and the response given was that, no, there wasn't a national standard and that --

COFFEY, Q.C.:

Q. That would come from whom?

DR. BRADBURY:

A. One of the pathologists participating in the teleconference.

COFFEY, Q.C.:

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Q. Okay.

DR. BRADBURY:

A. Further comment that all laboratories use their own protocols, and then the obvious question was asked was whether the same policy or the same fixation policy was in place throughout the various laboratories in the province as opposed to each of the laboratories having their own, and then again sort of a comment there going back to 2005 that these two reviewers, and these no doubt were the external reviews that Eastern Health had done, did identify over fixation as one of the variables in the testing results.

COFFEY, Q.C.:

Q. And you can't recall who was--so it would have had to have been presumably somebody from St. John's?

DR. BRADBURY:

A. Likely, likely.

COFFEY, Q.C.:

Q. So your sense up to this point--I stand to be corrected, I don't recall seeing any reference to under fixation up to this point, it's all over fixation, that was what you were hearing?

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DR. BRADBURY:

A. It was over fixation. The only comment that I've ever seen with regards to under fixation goes back to the memos from 2003. The director of the lab sent the memo out to the various pathologists talking about both over as well as under fixation with regards to immunohistochemistry testing.

COFFEY, Q.C.:

Q. That's that Ejeckam --

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Dr. Ejeckam's memo, is it?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. And you only would have become aware of those after this point?

DR. BRADBURY:

A. After this, correct.

COFFEY, Q.C.:

Q. And--sorry, go ahead.

DR. BRADBURY:

A. Okay. Can we move this?

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COFFEY, Q.C.:

Q. Yes, I certainly can.

THE COMMISSIONER:

Q. You have --

DR. BRADBURY:

A. Oh, I can do that?

THE COMMISSIONER:

Q. Yes, you can indeed.

COFFEY, Q.C.:

Q. You certainly can. So this almost looks like I'm starting to sort of summarize things here now. So we're talking about--so we've sort of moved on or doing some kind of summary here. I'm not quite sure why--sort of started ER/PR testing in St. John's, the comment is there. Fixation, process improvement piece, ongoing quality improvement, and then--so Dr. Dalton has finished making commentary about Central, and now we've moved on to Western, and Dr. Paul Neil, I recall, was dealing with--was participating from Western, and the comments he made at the time was he had good sort of turnaround time from Mount Sinai, was getting results back in less than a week, thought that they were good quality results, and presumably

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he expressed some general concern about the issues that we had discussed to date. He must have made some commentary then about sort of validation studies, quality assurance, fixation protocols. St. Anthony then, Dr. Dankwa was participating, and he made the comment about, you know, the technology particularly associated with this testing as changing all the time, that he recognized that fixation is an important aspect of particularly this test, and that the technology that's being used is also critical to the process, and he obviously made reference to the Ventana retrieval system and things which he described as being a more automated system. Okay. I can't read the first couple of sentences on the top.

COFFEY, Q.C.:

Q. To the left is certainly '97 through 2005 in the context here, without a doubt. "Conversion rates, question site specific or variances, plus or minus--minus or plus".

DR. BRADBURY:

A. Okay, this I think--and I can't recall if we actually discussed this or if this was sort of

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an issue that I identified myself that we didn't go on to specifically discuss because we're sort of--we're now talking about sort of error rates. I recall thinking to myself, and I don't recall asking the question out loud, was of the test results that were coming back that now had a change in their ER/PR status, whether there was a variation in the--sort of in the percentage conversion between the sites, and whether it was site specific or not.

COFFEY, Q.C.:

Q. Just on that point, and you think perhaps there was something that you, in effect, and I'll refer to it as probably doodling, in the sense, or kind of jotting a note down to yourself, was it actually discussed during that conference call because it would seem that it would be a fairly--kind of like the elephant in the room, as it were, proverbial elephant in the room in the context here.

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. You're talking to everybody across the

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province about what is going on, and perhaps what has gone on.

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. And an obvious question would be, well, what happened in each of the sites.

DR. BRADBURY:

A. Okay.

COFFEY, Q.C.:

Q. Or regions. So do you recall whether it was discussed?

DR. BRADBURY:

A. I assume it wasn't because I didn't make any notes regarding any of the conversation that we had.

COFFEY, Q.C.:

Q. And here just before you go on, I'll give you control of the mouse there, I believe it's "1997 biochemistry", arrow to pathology. Would you take us down through that?

DR. BRADBURY:

A. Okay. What I understood was that in 1997--I had previously described in giving the example of where a sample that was done sort of

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regionally, processed centrally, and then went out regionally for, you know, reading, interpretation, and reporting, that this was a model that I understood had been present in the late 1990s, that not only was it centralized testing, but the reporting was centralized as well. Subsequent to that, they had moved towards this centralized processing or testing, but that they had gone back or they had moved to a model of where the reporting was decentralized, and that the eventual plan then was to go back to the centralized reporting model with two or--and limiting the examination of the specimens to two or three pathologists, ideally with subspecialty or additional training in this area.

COFFEY, Q.C.:

Q. So your information, and here too at the top right hand side of this page, would have come from whom, do you recall, particularly in relation to the plan?

DR. BRADBURY:

A. No.

COFFEY, Q.C.:

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Q. But it did come up during the conversation?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Go ahead, ma'am.
DR. BRADBURY:
A. Okay.
COFFEY, Q.C.:
Q. I believe we'd gotten up to antigen retrieval techniques at the top of the page.
DR. BRADBURY:
A. Right, and these were, I assume, sort of continuing comments perhaps made by Dr. Dankwa, and I can't--like, other than to say I made those notes, I don't--what the comments or what the significance were of those three notes aren't clear from my shorthand.
COFFEY, Q.C.:
Q. It reads, "Antigen retrieval techniques, third party interpretation, and oncology review". That doesn't--okay.
DR. BRADBURY:
A. The first line no doubt has reference to the Ventana System.
COFFEY, Q.C.:

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Q. Yes.
DR. BRADBURY:
A. The third party interpretation, again I don't know if that has to do with this sort of modelling over here, or if it has to do with sort of the QA issue of a third party now having a look at some of the results, and the oncology review, I assume is in reference to the external review that was done.
COFFEY, Q.C.:
Q. I'm sorry, the --
DR. BRADBURY:
A. The external review that was done.
COFFEY, Q.C.:
Q. The external review would have been by --
DR. BRADBURY:
A. Oh, I'm sorry, I'm sorry, the oncology review, of course, would be the--I'm at a loss here now. You know, the panel that was looking at the results.
COFFEY, Q.C.:
Q. Because there's not an oncologist--I take it, no oncologist participated in this phone call?
DR. BRADBURY:
A. No, no.

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COFFEY, Q.C.:
Q. Was there any discussion do you recall during the phone call about or related to the notion or idea that oncologists should have picked this up before, could have picked this up before?
DR. BRADBURY:
A. I don't recall that, no.
COFFEY, Q.C.:
Q. I'm not suggesting there was. I'm just--because the word "oncology" kind of stands out here.
DR. BRADBURY:
A. Right, yeah.
COFFEY, Q.C.:
Q. Okay, go ahead, ma'am.
DR. BRADBURY:
A. So then there's sort of a "to do", and this would suggest that Eastern Health was in the process then--when I say "send a package", this would be in reference to the provincial fixation policy. So would send a package out to the regions regarding fixation, preparation, and there must have been some commentary about quality improvement, and this

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comment here about no site specific problems were identified, I--it isn't clear from this note if this is in response to this comment up here as to whether there was site variance in the conversion rate or not or if this had-- or if this was still Dr. Dankwa making commentary specific to his region.
COFFEY, Q.C.:
Q. In the context here, Dr. Dankwa would hardly know what went on in St. John's?
DR. BRADBURY:
A. That's right.
COFFEY, Q.C.:
Q. So it's--the assertion that no site specific problems were identified, could it have been in relation to the external reviews, or what was known to that date?
DR. BRADBURY:
A. I really can't comment.
COFFEY, Q.C.:
Q. Okay.
DR. BRADBURY:
A. So it looks like here now that --
COFFEY, Q.C.:
Q. Just before you go on, perhaps there's another

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way to ask the same question, but reframe it. By the time the conference call ended, did you have any sense that any one site had more of a problem than any other?

DR. BRADBURY:

A. No.

COFFEY, Q.C.:

Q. So your general impression was this was a province-wide problem?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

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

DR. BRADBURY:

A. Okay. So it looks like some of the issues that we've discussed are being repeated here, so that the ER/PR was being done in St. John's, HER2/neu in Mount Sinai, with the intention that it may be done here in a few month's time, some comment about quality process improvements, and then St. John's-- okay, so this sort of now starts to talk about some of the things that St. John's has done to ensure the integrity of the ER/PR testing that they were doing. Okay, so there were comments

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here about the retrieval techniques had changed. So that essentially had to do with both the Ventana System as well as some internal procedures that were being done within the lab, recognized that standards had changed with regards to the preparation of the fixation, the antigen retrieval, the percentage of staining that would now need to be standardized so that everybody was using the same scale for interpretation of positivity and negativity, and that the oncologists would be more directly involved with interpretation of the results.

COFFEY, Q.C.:

Q. The reference to Mount Sinai changed their initial diagnosis, do you recall what that-- right there.

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. It's on the same line as standards changed, brackets, Mount Sinai changed their initial diagnosis.

DR. BRADBURY:

A. Okay, from what I understood here, in the--

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somewhere around between 2003 and 2005, the percentage of staining changed in relation to what would be considered sort of a positive versus a negative result, and that previously, if I recall correctly, up to 30 percent--30 percent or more of the cells would have to stain in order for a test to be interpreted as positive, and the standards now changed so that, I believe, less than 1 percent would now be considered negative, 1 to 10 percent would be considered or described as a low expressor, so low percentage of staining, but may still benefit from Tamoxifen or some aromatase inhibitor medication, and then greater than 10 would be considered, you know, significantly positive. So because of the testing that Mount Sinai had done, extended over such a long period of time, like, from 1997 to 2005, that some of the earlier tests that were done, say, between '97 and for the first couple of years, because the standard had changed, a test that had bene reported as negative in ' 97 or '98, because of the changing standard, would now in sort of as of 2005 be considered positive. So I just made a comment that there

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were some cases here where Mount Sinai had changed the initial diagnosis because that standard had changed.

COFFEY, Q.C.:

Q. Mount Sinai's results had changed?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. The results coming from Mount Sinai?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Whatever they were, in some instances because the standards had changed -

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. - resulted in a change of view of it as being positive or negative?

DR. BRADBURY:

A. Right, right. And here was the explanation here, so it was in 2000. So in 2000 the cutoff was 30 percent staining, so anything 30 percent and higher would be positive, less than 30 percent, negative. And then after

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2000 the standard now sort of changed, so as I said, negative was now less than one percent and one to ten would be called the low expressors.

COFFEY, Q.C.:

Q. And who would have provided this information?

DR. BRADBURY:

A. One of the pathologists participating in the teleconference.

COFFEY, Q.C.:

Q. Would it have been one of them from St. John's?

DR. BRADBURY:

A. I can't comment.

COFFEY, Q.C.:

Q. Here on the top right-hand side the name "Khalifa" is written.

DR. BRADBURY:

A. I don't know why, I'm afraid.

COFFEY, Q.C.:

Q. Do you know Dr. Khalifa?

DR. BRADBURY:

A. I recognize the name, but it doesn't, it doesn't bring anything to mind.

COFFEY, Q.C.:

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Q. Okay. And then there's consensus?

DR. BRADBURY:

A. And so then, so this is sort of the laboratory sort of diagnosis of negative, low expressor and positivity. And then there was a consensus group that sort of now talked about, but the implications of these results into therapy, so with the idea being if a patient's results were described as being less than one percent, that that would be reported as being negative and that these patients typically would not be eligible for hormone treatment, but there always remains some treatment discretion then with regards to the clinical presentation with the oncologist and that one to ten percent were low expressors and greater than ten percent you would absolutely treat if there are no contraindications. And so it looks like then at this point in time the, you know, the large group teleconference finished.

COFFEY, Q.C.:

Q. What then happened, Doctor?

DR. BRADBURY:

A. As I recall, then I stayed on the line and had some further conversation. I mean, it was

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quite clear that, you know, the information needed to be as accurate as accurate could be and that there was a clear understanding of what the situation was in the province. And so what I recall then is several of the administrative people left the teleconference and then I, as the author of the briefing note, I stayed on line and then sort of had--went back through sort of the crafting of the briefing document or what I saw then as what the briefing document would look like with the pathologists who were participating in the first conference. So these were the questions then that I saw sort of arising from the conversation would be to describe in the briefing note sort of what the history of ER/PR testing was in the province, what the current status was with regards to the plans for testing, then what Eastern Health's plan was on a go-forward basis, not only for with regards to testing but sort of also what they planned to do from a QA point of view. And then there was that question then about what were the problems, if any, that had been identified and then sort of I was going to e-

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mail the three--the response then to these three questions out to the RHAs then for their response.

COFFEY, Q.C.:

Q. So did you ever do that?

DR. BRADBURY:

A. The briefing note was prepared. And to be quite frank, I think it was sent out to the RHAs not very far in advance of it being, you know, given to the deputy minister and minister in advance of the house opening that afternoon.

COFFEY, Q.C.:

Q. Now, this question, "Region specific, what were the problems?" The first bullet is question, "Region specific."

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. Was that ever answered?

DR. BRADBURY:

A. The only reference that I see to that in my notes goes back to that single line that there didn't appear to be anything that was regionally specific.

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COFFEY, Q.C.:
Q. Now here, just in looking at this, was this, in fact, and I appreciate this is page nine of eleven of this exhibit, here in the top right-hand side there's Terry Gulliver and Heather's names?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. That would be Heather Predham?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. I take it this--did this occur during that conference call?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Okay. Perhaps then you could take us on then?
DR. BRADBURY:
A. Okay. So like I said, we have our sort of minds wrapped around what we anticipate the questions might be arising in the house and how we would fashion the answer. And so the first question had to do with what was the

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current status of ER/PR testing in the province, okay. And again, so what I did was I broke it out into three time periods, sort of what had happened sort of pre 2005, what had happened then in late August, 2005 up to February when Eastern Health then had restarted the ER/PR testing and then also made--this had to do more with commentary about what they saw sort of going into the future.
COFFEY, Q.C.:
Q. Why did you note Mr. Gulliver and Ms. Predham's name on the top right-hand side?
DR. BRADBURY:
A. I would assume that they were participating in the teleconference. Can't otherwise give you an answer to that one, I'm afraid.
COFFEY, Q.C.:
Q. And but they would have been just two of quite a number of participants?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Did you keep any list of the participants?
DR. BRADBURY:

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A. The notes that I provided you were the sort of the complete list that I had. So the, you know, the names that I'm giving you really are from recall.
COFFEY, Q.C.:
Q. Okay. And in relation to this, like these notes here we're looking at on this page, page nine of the exhibit, these were made at the time as you're listening to people and kind of mapping it out?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. And I take it writing it down or getting information, writing it down and confirming that -
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. - it's correct?
DR. BRADBURY:
A. As I said, it became sort of evident from the earlier conversation it was--it wasn't just a simple question as what is the status of ER/PR in the province. There was ER/PR, there was

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also Herceptin and there was also sort of the, you know, the changing situation of what had been done previously, what, you know, what had been done in the near past, what the current status was and, of course, then, you know, the anticipated changes.
COFFEY, Q.C.:
Q. Okay. So -
DR. BRADBURY:
A. So I fashioned it in this way because I anticipated that that was sort of how I was going to map out the briefing note.
COFFEY, Q.C.:
Q. Okay, so the pre--in the column entitled "Pre 2005" you got "centralized testing" with an arrow leading to "regions"?
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. "For reporting interpretation."
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. ER/PR and HER2/neu."
DR. BRADBURY:

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A. Right. So this, what this just reconfirmed the situation. And we had looked at the example of Gander where you would have a specimen taken regionally, that it would be grossed and processed centrally, but then it would go back out to the region that had initially referred it for interpretation and reporting, okay.

COFFEY, Q.C.:

Q. And then the column entitled "2005 to 2007."

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. Reads, "August, 2005 to February 1st, 2007"?

DR. BRADBURY:

A. Right. And this suggested that during this time frame that all ER/PR as well as HER2/neu specimens were going, all were being sent to Mount Sinai. And then at the same time that these specimens, say, were being sent sort of on a sort of in a real-time basis, Mount Sinai then was also looking at what I describe here as sort of older, older specimens between 1997 and 2005.

COFFEY, Q.C.:

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Q. July, 2005, yes.

DR. BRADBURY:

A. Okay. And that they were reviewing sort of--I wrote here, "all old samples," okay, and someone clearly made a reference to, you know, the approximate number of breast specimens that would have been there around that time period.

COFFEY, Q.C.:

Q. Which is "3000 patients" is written there and you've crossed that out?

DR. BRADBURY:

A. Talked about 3000 patients, but then crossed that out and it looks like I wrote down "27 and eight specimens."

COFFEY, Q.C.:

Q. Yes.

DR. BRADBURY:

A. So presumably at some point in time we had the conversation about we would talk about it more in terms of specimens. This would suggest that there must have been, you know, a number of patients who, you know, who perhaps didn't--I mean, if the numbers are correct, it would suggest that a number of patients perhaps did

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not have this testing done.

COFFEY, Q.C.:

Q. So then there's a reference to, I believe it's, whatever the figure underneath is it's 939, I believe?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. And you've got "retesting" the word "retesting" is crossed out and the word "patients" written there. See that?

DR. BRADBURY:

A. That's right. So my understanding here, and to be quite frank, sort of this is, it was this sort of very brief discussion that we had about the numbers. And this was really my first exposure to, you know, talking about the number of specimens and the number that had gone to Mount Sinai. When I finished the--like, the focus of the teleconference really wasn't on the numbers. As I said, we were talking about what was the status of testing, some of the QA, you know, what some of the problems that were identified were. I wasn't--I didn't feel comfortable that I had a clear

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understanding of what these numbers were. And with the luxury of some time then it was because of this then I initiated the phone call to Heather Predham on June 1st just to try and get a better sense of what these numbers that we went through very quickly in this teleconference actually meant.

COFFEY, Q.C.:

Q. You've got here "213"?

DR. BRADBURY:

A. Right.

COFFEY, Q.C.:

Q. And there appears to be almost a equal sign there?

DR. BRADBURY:

A. Yeah. And it looks like of the 213, 138 had received Tamoxifen, 117 had a change in treatment. And then I talk about conversion rate and it looks like the conversion rate maybe was ten percent in 2001 onward in the specimens as opposed to there was a conversion rate of 30 percent in the specimens that were sent out between 1997 and 2001.

COFFEY, Q.C.:

Q. So do you know if that's so or is that simply

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the positivity rates?
DR. BRADBURY:
A. This -
COFFEY, Q.C.:
Q. Because it would, again -
DR. BRADBURY:
A. I would interpret this as when I described the conversion rate here, I would be talking about the samples that went to Mount Sinai that initially had been reported as being ER negative that converted to ER positive on the retest.
COFFEY, Q.C.:
Q. And in the context of this here, I take it, you would have been getting those numbers from people who were participating?
DR. BRADBURY:
A. Yes. And -
COFFEY, Q.C.:
Q. Who gave them?
DR. BRADBURY:
A. I don't recall specifically, but it would have been someone from Eastern Health.
COFFEY, Q.C.:
Q. Okay. In the sense here then, because you've

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got, and you're very particular, you've got the word "conversion rate" there and there's a, I don't know the proper name for this.
DR. BRADBURY:
A. Parenthesis.
COFFEY, Q.C.:
Q. Okay, parenthesis is one way to describe it. Here, and you are meaning here by utilizing this, they are your notes, the conversion rate, you understood, at the end of the phone call, was ten percent for the specimens from 2000 onward, 2001 onward and 30 percent of those between '97 and 2001 had converted?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. On retest, that was what you understood at the time?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Anything else come to mind then in relation to that part of--you got below here, some other numbers here, "less than 30 percent retest, less than ten percent retest and Tamoxifen,

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false negatives."
DR. BRADBURY:
A. I don't--I'm not sure if that 30 percent and ten percent had to do with up here or if this starts to get at the issue about the change in sort of in the, you know, in the measurement standard, you know, the 30 percent you would treat versus, you know, the standard now of it going less than ten percent. So then when we get into the third column, it talked about sort of in today's environment. Talked about ER/PR testing. And then made reference then to the increased automation of the retrieval system through the implementation of the Ventana system. We identified that the external reviews were done. And -
COFFEY, Q.C.:
Q. It says, "External reviews were implemented," in fact, I believe, are the words?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. What did that mean?
DR. BRADBURY:
A. It talks about, I think that this has to do in

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relation to number two, we're talking about proficiency testing and then just made sort of "were implemented."
COFFEY, Q.C.:
Q. Okay.
DR. BRADBURY:
A. Okay. And then the third thing talks about--and again, we referenced it before was they talked about going to a model where there would be pathologists that were dedicated to interpretation of the specimens rather that it being distributed sort of throughout them all. This is a comment then that testing is only being done in St. John's. Some of the tests that they had subsequently been doing a second read at Mount Sinai from a QA point of view, that there was good correlation. And then the last column has to do--sorry. The last column, did I lose -
COFFEY, Q.C.:
Q. Perhaps I'll just -
DR. BRADBURY:
A. Okay, do you want to -
COFFEY, Q.C.:
Q. I'll search down there.

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DR. BRADBURY:
A. And then the last column just sort of, you know, talked about where we were, where we were going, so talked about standardization of the fixation policy that this being sort of a provincial policy rather than laboratory specific. And then the plan then to introduce the HER2/neu as well as bring ER/PR back for all of the province and then to move to the model of centralized processing as well as reading interpretation and reporting. And then there's a comment here, "When able."
COFFEY, Q.C.:
Q. And that in this context meant what?
DR. BRADBURY:
A. In the context of certainly in May, 2007 Eastern Health had a significant problem with both recruitment and retention of pathologists and there were several vacancies at the time. And so that was certainly recognized as being a factor as to when they would be able to consider bringing in specimens from outside of St. John's.
COFFEY, Q.C.:
Q. Let's go on then to the next page.

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DR. BRADBURY:
A. Okay. So this goes on to describe some of the things that Eastern Health then had introduced sort of both in response, say, to the external reviewers as well as to make improvements in their QA programs. So they had recruited four new pathology assistants and they had introduced sort of the immunohistochemistry, they had now created a separate department. They had drafted provincial policy on fixation and were attempting to sort of standardize tissue sampling. They had upgraded the retrieval system and gone to the automated Ventana. They talked about dedicated technicians and pathologists with additional training. New director of immunohistochemistry. The sort of centralized reporting service. And then they were doing some external QA testing and things for proficiency and they were sending some blind samples or they were receiving blind samples from the UK that they were doing interpretations on and stuff looking at the, you know, the concurrence and diagnosis. And then they were also sending random--random

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samples were going to Mount Sinai again for sort of a second read and, you know, looking for concurrence in diagnosis. And at that point in time these random samples that were being sent since February, 2007 when they had restarted testing in St. John's, there was 100 concurrence with the Mount Sinai reviews. And that, I believe--okay, so since suspending the test, what was happening then with testing in the province, as I say, we're talking now about sort of quality assurance and proficiency testing. As I said, there was 100 percent concurrence. Made the comment about if outside lab is properly fixing and sampling the blocks, and then just a further reference then to the HER2/neu process. So again, because of the antibody system had changed for HER2/neu, the technologists were in the process of doing some validation, but currently St. John's was sending out and that this validation would happen over the summer 2007. And that presumably was the end of the teleconference.
COFFEY, Q.C.:
Q. So Doctor, where were you when you took part

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in this teleconference?
DR. BRADBURY:
A. I was up in the executive boardroom of the Department of Health.
COFFEY, Q.C.:
Q. And who was there with you at the time?
DR. BRADBURY:
A. I recall, at least for some of--at least for the first part of the meeting, Moira Hennessey, and John Abbott, and I don't recall anyone else.
COFFEY, Q.C.:
Q. Okay. Now having finished the conference call, what did you do?
DR. BRADBURY:
A. Wrote up the briefing note for questions and answers.
COFFEY, Q.C.:
Q. If we can bring up, please, Exhibit P-0126?
REGISTRAR:
Q. What page was that?
COFFEY, Q.C.:
Q. Actually, it's page 45, Commissioner, actually this particular briefing note, but before I go to that, I'd like, as well, to look at Exhibit

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P-0454. I apologize, I'm--P-0894. I apologize, Registrar, Commissioner. Yes. No, 0894. Yes.

THE COMMISSIONER:

Q. All transposing our numbers today.

COFFEY, Q.C.:

Q. Thank you, Registrar. This is a--there are two e-mails, one of May 24th, 2007 at 2:18 p.m. from yourself to a number of individuals. I take it these would have been participants in the conference call.

DR. BRADBURY:

A. Should have been, yes.

COFFEY, Q.C.:

Q. Yes. They're Larry Alteen, Karen McGrath, George Tilley, Oscar Howell, Bonnie Boudreau, Michael Jong, Boyd Rowe, Ken Jenkins, Susan Gillam, Ed Hunt, John Abbott, Nash Denic. Certainly, I've covered at least some of them. You wouldn't have had the e-mail addresses, I take it, for people like Maurice Dalton?

DR. BRADBURY:

A. Correct.

COFFEY, Q.C.:

Q. Paul Neil and company. And you write, "please

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find attached a briefing that was provided to the Minister in follow up to our teleconference this morning. I don't have the e-mail addresses for all participants other than CEOs and VPs of Medicine. Please forward the document to other teleconference participants within your RHA. Thanks, Cathi." And at 8:00 that night, Nash Denic e-mailed you back saying "thanks, Cathi. It is as we discussed." Signed Nash.

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Had you discussed this with Nash, the briefing note itself, before you sent it out?

DR. BRADBURY:

A. I don't recall.

COFFEY, Q.C.:

Q. I'm not going to say that no one else--do you recall if anybody else responded? Because this is one that kind of stands out as a response.

DR. BRADBURY:

A. I don't recall getting confirmation from anybody else, no.

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COFFEY, Q.C.:

Q. Okay, and if we could look then, please, at Exhibit P-0892? This is an e-mail from Betty Donahue, administrative assistant to the DM. Is she your or Dr. Hunt's?

DR. BRADBURY:

A. No, she would be the administrative support for the Deputy Minister.

COFFEY, Q.C.:

Q. Okay, of the DM, yes, Mr. Abbott. So at 1:16, she sent you something, an ER/PR update, May 23rd 2007. It's written "as discussed." Do you recall what that was?

DR. BRADBURY:

A. No, I don't.

COFFEY, Q.C.:

Q. Okay, and if we could look then at P-0126, page 45? I take it that this is the briefing note for the Minister of Health of May 24th, 2007, prepared by yourself?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Now the issue is simply phrased as ER/PR testing for breast cancer, and then the

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background was set out, the anticipated questions, and which is there's just one of them, "what is the current status of ER/PR testing in the province?" and you have the response there. I take it that response relates to that question?

DR. BRADBURY:

A. Yes.

COFFEY, Q.C.:

Q. Okay, and then number two is "what is the province's plan for ER/PR testing on a go-forward basis?" and then there's an actual response written there.

DR. BRADBURY:

A. Yes. These are questions that we anticipate may be asked in the House, sort of based on, you know, for example, number one was, as I understand it, sort of the question that had been asked in the House the day before.

COFFEY, Q.C.:

Q. Yes.

DR. BRADBURY:

A. And so this was to provide the Minister then with an update or a briefing in order to address this outstanding question from one of

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the members of the House.
COFFEY, Q.C.:
Q. And Ms. Bradbury, did you have any assistance in formulating these answers?
DR. BRADBURY:
A. Assistance you mean from someone actually writing this?
COFFEY, Q.C.:
Q. Yes.
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. Okay. Had you ever prepared a briefing note like this before?
DR. BRADBURY:
A. You mean briefing notes for Question Period versus ER/PR testing?
COFFEY, Q.C.:
Q. Briefing note for Question Period.
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. So you'd done that a number of times before?
DR. BRADBURY:
A. Yes.

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COFFEY, Q.C.:
Q. And the style that's followed here, anticipated questions and they're listed in bold -
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. - print, with a question mark, and they're answered generally in bullet form and sometimes in bullet form with bolded headings, okay. Was this any particular style that you had followed before, the formatting is what I'm talking about?
DR. BRADBURY:
A. The format typically with most of our briefing notes, you start off with a small background or a statement and then typically you would anticipate or identify three or four possible questions on the topic and then in bullet form, you know, provide information for the Minister so that he could respond to such a question, if asked.
COFFEY, Q.C.:
Q. But this one doesn't do that. You can see that there is a question and then an actual

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answer. There's not a list of questions and then a list of possible answers. This is not an anticipated questions, key messages approach. This is an anticipated questions, an actual question and an actual answer. So I'm asking you, because we've seen a number of them, and in fact, if I go through this exhibit, before and after it, there are briefing notes, Q & A briefing notes.
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. That have issues, they have anticipated questions and they have key messages. That's the way that it's approached. So I'm just asking you, here in this context, your approach, does this mirror your approach in other--the format?
DR. BRADBURY:
A. It mirrors my approach.
COFFEY, Q.C.:
Q. Your approach, and here in drafting these answers throughout this, did you attempt to be as accurate as possible?
DR. BRADBURY:

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A. Yes.
COFFEY, Q.C.:
Q. And in formulating your answers, were you being careful to omit anything?
DR. BRADBURY:
A. No, no.
COFFEY, Q.C.:
Q. Okay, I'm not suggesting you were. I'm just asking you, okay. So it was questions you anticipated would be asked and an actual answer to the best of your knowledge?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. Okay. Now here, Doctor, "what is the current status of ER/PR testing in the province?" You point out it has resumed in St. John's and ER/PR testing was being referred out to Mount Sinai at the same time. New protocol was instituted for HER2/neu, and you talk about that, and the plans to reinstitute HER2/neu testing for St. John's. ER/PR HER2/neu pre-2005, August 1, 2005 to January 31, 2007, February 1, 2007, and that just kind of factually, as best you knew, laid out what was

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going on?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. "What is the province's plan for ER/PR testing on a go-forward basis?" "With agreement of the four RHAs and the Department of Health and Community Services, it is intended that the testing, interpretation and reporting of all specimens in the province for ER/PR and HER2/neu will occur at the St. John's centre of excellence." Okay? The phrase "centre of excellence," where had that come from?
DR. BRADBURY:
A. I think it--I mean, it's a relatively common term that we would use, particularly in, sort of in the medical field where facilities are identified or sort of looked at as being sort of centres of excellence. For example, for neurosurgery or, you know, for cardiac care. So it's a functional recognition of a centre.
COFFEY, Q.C.:
Q. But in this context of ER/PR, the St. John's site, centre of excellence, where had you heard or seen that term used in relation to

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ER/PR and HER2/neu testing?
DR. BRADBURY:
A. I don't recall.
COFFEY, Q.C.:
Q. Would you, in preparing this, have had access to and utilized any earlier briefing notes?
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. So in this context, it would have been something that even if you hadn't written it, haven't written it down, you would have heard someone refer to it?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. In this context. And then, here in terms of the plan for ER/PR testing on a go-forward basis, there's no actual reference here to--it says it's intended, but the actual time frames are not spelled out.
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. Why was that?

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DR. BRADBURY:
A. There were two primary issues, I think, identified sort of, again, relating back to the teleconference that they were limited with regards to resources. So they--so in order for them now to take on additional responsibility while they were short physicians was a challenge. Then, at the same time, sort of they were continuing to implement the recommendations that had been made as part of the external review process. So it was seen as where they wanted to go, but that they weren't able, at the present time, to get there, primarily because of resources.
COFFEY, Q.C.:
Q. But in terms of there are references to, in the notes we just looked at, end of summer, end of '07 or February of--January or February of '08, you had thought maybe at one point it might refer to. So the estimates of time, you chose not to put in here at the time.
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. And that would be because they were uncertain

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from your perspective?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Finally, number three, "what changes have been implemented following the external review of ER/PR testing to ensure quality reporting?" and you've written "Eastern Health has undergone an extensive external review of its policies and procedures related to ER/PR testing and are in the process of implementing recommendations arising from the review. Examples of these actions include, but are not limited to," and there are one, two, three, four, five, six, seven, eight bullets. Now had you seen the external review reports up to this point?
DR. BRADBURY:
A. At that point in time, no.
COFFEY, Q.C.:
Q. How did you--you talk about they were in the processing of implementing recommendations arising from those reviews, examples of the actions which would be the implementations of the recommendations are listed. There are

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eight of them here. How did you know what they were?
DR. BRADBURY:
A. To produce the actual list?
COFFEY, Q.C.:
Q. Yes.
DR. BRADBURY:
A. This would have been information provided to me by the participants from Eastern Health in the teleconference.
COFFEY, Q.C.:
Q. So it was your understanding that during the teleconference, they were informing all participants of certain of the recommendations anyway that these external reviewers had made? Not all of them necessarily, but certain of them.
DR. BRADBURY:
A. These were certainly given as examples of things that they had done, and -
COFFEY, Q.C.:
Q. And they had linked that though to the external reviewers recommendations?
DR. BRADBURY:
A. Yes.

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COFFEY, Q.C.:
Q. And so the first of them is "development and implementation of a province wide policy to standardize the sampling and preparation (fixation) of specimens. Establishment of a separate immunohistochemistry department for hormone based testing. Recruitment of four pathology assistants. Upgrading of the Ventana system automated process for the retrieval of hormone markers. Dedicated technologists and pathologists to report on these tests who have received additional training in this area. Implementation of a new director of immunohistochemistry. External quality assurance program for proficiency testing, receive blind samples from the UK for testing here and comparison to international results and the College of American Pathologists, and continuing to send current random samples to Mount Sinai for reconfirmation of interpretation and results. To date there have been 100 percent concurrence with Mount Sinai results."
Now in giving that answer, did you anticipate and intend that the Minister could utilize that in answering that question?
DR. BRADBURY:
A. Yes.
THE COMMISSIONER:
Q. Mr. Coffey, we're getting to the point of the afternoon break. We're probably past it actually.
COFFEY, Q.C.:
Q. Yes, if we could break now, Commissioner, I'll come back and finish up, thank you.
THE COMMISSIONER:
Q. Okay then.
(BREAK)
THE COMMISSIONER:
Q. Please be seated. Mr. Coffey.
COFFEY, Q.C.:
Q. Thank you, Commissioner. Dr. Bradbury, again just looking at C-0126, page 46, which is there on the screen. External reviews, reviews, yes, it would be reviews, in plural, of ER/PR testing, you had understood that they had gone on. I take it that understanding dated all the way back to Dr. Williams first speaking to the group in September 2005?
DR. BRADBURY:

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A. The information that's listed here are the responses that Eastern Health would have provided on the teleconference when I asked them this sort of specific question in anticipation of, you know, including this question in the briefing note.
COFFEY, Q.C.:
Q. No, I was asking you about the idea of or the existence of such external reviews, your own-- they first came to your attention when, the fact that there had been external reviews?
DR. BRADBURY:
A. Dr. Williams referenced it in one of the VP meetings, but I don't recall which one it was.
COFFEY, Q.C.:
Q. And in that context, he told you what?
DR. BRADBURY:
A. I don't recall any detail other than the fact that he indicated to the VPs of Medicine that external reviews had occurred.
COFFEY, Q.C.:
Q. And did you have any understanding at that time about what the nature of those was?
DR. BRADBURY:
A. No.

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COFFEY, Q.C.:
Q. Were they peer reviews or anything like that, was that talked about at the time?
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. Okay, just said we brought a couple of people in from outside and they had a look. Dr. Bradbury, before the teleconference that you've described on May 24th, was there any discussion in the Department, to your knowledge, involving yourself or that you overheard, involving the Department obtaining those reviews, the actual reports?
DR. BRADBURY:
A. I have no knowledge of the conversation within the Department on that issue.
COFFEY, Q.C.:
Q. How about after that?
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. During the conversation, this teleconference, did anyone actually ask what's in the external reviews?

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DR. BRADBURY:
A. Not that I recall.
COFFEY, Q.C.:
Q. If we could bring up, please, Exhibit P-1723? Now Doctor, before we look at this, because it's dated June 1, 2007, were you involved in the ER/PR matter then after you prepared the briefing note of May 24th?
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. When did you next get involved in it?
DR. BRADBURY:
A. Well, as I had indicated earlier, we briefly--during the teleconference of May 24th, we briefly touched on some of the numbers with regards to the number of specimens that were sent to Mount Sinai, number that had converted and I had indicated at the end of the teleconference, I wasn't comfortable that I understood sort of the Mount Sinai process and the numbers involved and so in anticipation that I may be asked to provide additional consultancy or opinions within the Department, I decided to contact Heather Predham to get some more information.
COFFEY, Q.C.:
Q. Why did you anticipate you might be consulted?
DR. BRADBURY:
A. It was an active issue in the house and so it wasn't unreasonable to expect at that time that I might be asked to participate in a similar process to what had occurred on May 24th.
COFFEY, Q.C.:
Q. So you then called or contacted Ms. Predham. I take it you phoned her?
DR. BRADBURY:
A. Yes. I phoned her on June 1st, 2007.
COFFEY, Q.C.:
Q. And what is "PC"?
DR. BRADBURY:
A. Phone call.
COFFEY, Q.C.:
Q. Phone call. And go ahead, these are your notes of the conversation, I take it?
DR. BRADBURY:
A. Yes. So the information that I gleaned from Heather was that the Mount Sinai review involved patients between--patients who were

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tested between 1997 and 2005. I was given a number of total patients and it would appear even that number was unclear.
COFFEY, Q.C.:
Q. You had 939 there and you've got two question marks outside the circled 939?
DR. BRADBURY:
A. That's right. I don't recall at what point in time I questioned that number and when I put the second number in.
COFFEY, Q.C.:
Q. The second number is 763 inside a bracket?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. Or brackets with two question marks next to it?
DR. BRADBURY:
A. That's right. So it looks like I had either added to or made an alteration to the note at some point in time and I don't know when that occurred. I then go on to describe that, as I understood it, that Eastern Health was in the process of retesting all patients who were initially ER negative and those patients only.

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So they weren't retesting all of the patients that had been--that had received this diagnostic test between '97 and '05, only those that were initially reported as ER negative, okay. And so then I go on to describe that the number of conversions were 330 and of this 330 13 had converted because of this changed definition. So that's gets at the issue of 30 staining now, the one to ten percent being low expressor, so the change in the definition of positivity that had occurred around 2000. And so then of the 330 with 13 changing by the definition change, then there were 317 that converted for other reasons. Of those I understood four had had a change in the -

COFFEY, Q.C.:

Q. I'm sorry, how many? Run that last thing past me again?

DR. BRADBURY:

A. Okay. So the 330.

COFFEY, Q.C.:

Q. Yes.

DR. BRADBURY:

A. Take away the 13 who had converted because of

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a change in the definition.

COFFEY, Q.C.:

Q. Yes.

DR. BRADBURY:

A. 317 had a change in their diagnosis or sort of in their ER status.

COFFEY, Q.C.:

Q. Okay, yes, okay.

DR. BRADBURY:

A. Okay. And of those 317, as I understood our conversation, four patients had a change in their original pathological diagnosis. So that would suggest that there was a change that was outside of the ER issue, but had more to do with, you know, whether it was a sort of whether the, you know, it was carcinoma in-situ verses invasive. So there was some change in the pathological diagnosis rather than just their ER/PR status. That 96 patients were reported--had converted and would be identified as being a false negative as in they were reported as being ER negative initially and had converted to ER positive and of these 96 they were recommended for changes in treatment. And of course, the change in

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treatment would now mean that they would be recommended to receive Tamoxifen or some other Aromatase inhibitor. And there were also 213 that could be described as being false negative. However, despite being identified as being false negative, that as a result of being panelled there was no change in the initial treatment being recommended. And of these 213 the reason why despite the fact, say, these individuals now being ER positive, there was no change in treatment recommended because 60 were identified as being at low risk of reoccurrence, 148 of them were already on Tamoxifen and some of them, for example, were on Tamoxifen because of their PR status rather than their ER status. There were 13 patients who already had metastatic disease that were now on Tamoxifen. And there were five patients in this group where at that point in time the panel had not reached a consensus as to what the recommendation for treatment was and that these five cases needed to be reexamined.

COFFEY, Q.C.:

Q. So the 213 false negatives is the sum of 60,

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148 and five? If you add 60, 148 and five?

DR. BRADBURY:

A. In theory it should be. When you look at it, it isn't. Or is it? Yes, it is, sorry, yes, it is.

COFFEY, Q.C.:

Q. It is. And the 13 with metastatic disease now on Tamoxifen were part of the 148 who by the time of the panelling were already on Tamoxifen?

DR. BRADBURY:

A. Correct.

COFFEY, Q.C.:

Q. Okay. So you made these notes. Would Ms. Predham have understood, do you think, at the time, that you were making your inquiries on behalf of the Department of Health?

DR. BRADBURY:

A. No doubt she was familiar with my name. I would have indicated to her, you know, the purpose for my call and that I was calling, as I said, in sort of my capacity or anticipated role with the department so that I better understood the number, numbers.

COFFEY, Q.C.:

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Q. Did you have any--do you recall any further discussion you had with her at the time?
DR. BRADBURY:
A. No.
COFFEY, Q.C.:
Q. What then did you do with this information?
DR. BRADBURY:
A. This was just information that I kept for my own purposes.
COFFEY, Q.C.:
Q. And did you have any further involvement in the ER/PR matter?
DR. BRADBURY:
A. Personally, no. Shortly, within a week or two of the teleconference of May 24th the assistant medical director was involved in a sort of a subsequent meeting or conference about another issue that I believe had arisen in the house and then after his involvement -
COFFEY, Q.C.:
Q. That would -
DR. BRADBURY:
A. - he provided a short, a short briefing to me.
COFFEY, Q.C.:
Q. That would involve the Dr. Ejeckam memos?

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DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Okay. And that other individual was whom?
DR. BRADBURY:
A. Dr. Blair Fleming.
COFFEY, Q.C.:
Q. And so he provided a briefing to you about the Dr. Ejeckam memos?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. What do you recall about that? Well, first of all, why did he brief you?
DR. BRADBURY:
A. Well, I anticipate that I was either away or unavailable that day to participate myself personally, and so Dr. Fleming would have participated in my stead. And in situations like that, typically upon my return I would meet with him and, you know, we would just discuss, you know, significant issues that had occurred sort of in my absence.
COFFEY, Q.C.:
Q. So this would be, I take it, early June, 2007?

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DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. Can you tell the Commissioner then, kind of, why are you involved at this point? You hadn't been involved up until May 24th, you've told us?
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. And so why are you now involved?
DR. BRADBURY:
A. I don't -
COFFEY, Q.C.:
Q. In what capacity?
DR. BRADBURY:
A. I really don't have an explanation for that other than,l as you saw from the e-mail, I was asked to participate in the teleconference by the deputy minister.
COFFEY, Q.C.:
Q. And I appreciate that. But you've referred to Dr. Fleming in your absence having gone to a meeting and he took the trouble to brief you when you came back?

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DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. So I take it then that that suggests that if you had been around, it would have been you and not Dr. Fleming who went to the meeting?
DR. BRADBURY:
A. Yes.
COFFEY, Q.C.:
Q. To discuss the Dr. Ejeckam memos. So he briefed you on the memos. Do you recall what, if anything, he told you about them?
DR. BRADBURY:
A. He had identified that most of the conversation had focused on other immunohistochemistry tests that had been documented in Dr. Ejeckam's memos of, I believe, 2003.
COFFEY, Q.C.:
Q. The CK34 lymphoma marker?
DR. BRADBURY:
A. Right.
COFFEY, Q.C.:
Q. Antibodies and the other six out of the eight. What, okay, so what did he tell you about

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that?
DR. BRADBURY:
A. The information, as I recall, was that the other immunohistochemistry tests that he had identified in his memo of 2003 were in a different class of tests than the ER/PR. So he differentiate between what he described as a class one and a class two test and went on to further describe that the class one immunohistochemistry tests are really used sort of as an adjunct or to sort of further help to define your original diagnosis. They aren't typically involved with sort of determining eligibility or treatment protocols and often times are used in conjunction with other tests, for example, like cytology or I think he used the term FISH type procedures. So as opposed to the class two which ER/PR sort of stand alone there and that they would be the sole test that would typically, from a testing point of view, be used to determine treatment plans.
COFFEY, Q.C.:
Q. I take it this was all in relation to determine whether it was necessary to make

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further inquiries about these other six antibodies?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. And the tests that had been done over the years with them?
DR. BRADBURY:
A. Correct.
COFFEY, Q.C.:
Q. Okay, having been briefed by Dr. Fleming, what, if anything, did you do?
DR. BRADBURY:
A. To the best of my recollection I had sort of no further formal involvement with this matter.
COFFEY, Q.C.:
Q. How about informal?
DR. BRADBURY:
A. Not that I recall, I mean, other than perhaps sort of a casual conversation, but no specific meetings or teleconferences or briefing notes or -
COFFEY, Q.C.:
Q. Thank you, Commissioner.

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THE COMMISSIONER:
Q. Thank you. Mr. Simmons?
MR. SIMMONS:
Q. I have no questions, thank you.
THE COMMISSIONER:
Q. Mr. Browne?
MR. BROWNE:
Q. No questions, thank you, Dr. Bradbury.
THE COMMISSIONER:
Q. Mr. Pritchett?
MR. PRITCHETT:
Q. I have no questions.
THE COMMISSIONER:
Q. Ms. Brocklehurst.
MS. BROCKLEHURST:
Q. No questions, thank you, Commissioner.
THE COMMISSIONER:
Q. Mr. Pritchard?
MR. PRITCHARD:
Q. I don't have any questions, Commissioner, thank you.
THE COMMISSIONER:
Q. You probably have the record.
MR. PRITCHARD:
Q. Her answers were so complete.

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THE COMMISSIONER:
Q. Well, thank you, very much, Dr. Bradbury, for returning after such a lengthy period of time to complete your testimony. I regret that it was that long, but I'm glad you were able to return and complete it. We very much appreciate it.
DR. BRADBURY:
A. Thank you.
THE COMMISSIONER:
Q. I guess we now adjourn until Monday.
COFFEY, Q.C.:
Q. Yes, in accordance with your earlier comments a couple of days ago, Commissioner, I'll be back on Monday with, I believe it's Dr. Kwan first thing in the morning. Mr. Browne is nodding, so that's it.
THE COMMISSIONER:
Q. Mr. Browne keeps track of these things. Thank you. Well, in that case, enjoy your weekend.
Adjourned.

CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the Commission of Inquiry on Hormone Receptor Testing, heard on the 25th day of September, A.D., 2008 before the Honourable Justice Margaret A. Cameron, Commissioner, at the Commission of Inquiry, St. John's, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John's, Newfoundland and Labrador this 25th day of September, A.D., 2008

Judy Moss

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