

<p style="text-align: center;">COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p style="text-align: center;">BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p style="text-align: center;">APRIL 28, 2008</p> <p>Appearances: Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Megan Collins Her Majesty in Right of NL</p> <p>Peter Browne/Jane Hennebury Doctors Kara Laing et al</p> <p>Daniel Simmons/Sarah Learmonth . . . Eastern Regional Integrated Health Authority</p> <p>Darlene Russell. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike NL Medical Association</p> <p>Jennifer Newbury Canadian Cancer Society (NL Division) Stacey O’Dea Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p style="text-align: center;">LIST OF EXHIBITS</p> <p>EXHIBITS P-0029, P-0030, P-0031 Pg. 5</p> <p>EXHIBITS P-0700 THROUGH P-0775 Pg. 5</p> <p>EXHIBITS P-0486, P-0487, P-0488 Pg. 5</p> <p>EXHIBITS P-0776 THROUGH P-0783 Pg. 132</p> <p>EXHIBIT P-0784 Pg. 325</p>
<p style="text-align: center;">TABLE OF CONTENTS</p> <p>MS. LOUISE JONES - SWORN</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 5 - 439</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER: 2 Q. Please be seated. Ms. Chaytor. 3 CHAYTOR, Q.C.: 4 Q. Good morning, Commissioner. Our witness today 5 is Louise Jones. 6 THE COMMISSIONER: 7 Q. All right. 8 CHAYTOR, Q.C.: 9 Q. Good morning, Ms. Jones. 10 MS. JONES: 11 A. Good morning, Sandy. 12 CHAYTOR, Q.C.: 13 Q. Commissioner, we have exhibits that we’ll be 14 referring to during Ms. Jones’ evidence today. 15 They are P-0029 through to P-0031 inclusive. 16 THE COMMISSIONER: 17 Q. Are they entered already? 18 CHAYTOR, Q.C.: 19 Q. No, those are new. 20 THE COMMISSIONER: 21 Q. P-0029 to 0031? 22 CHAYTOR, Q.C.: 23 Q. Yes, I can explain the low numbers, but - 24 THE COMMISSIONER: 25 Q. There were numbers earlier on that we -</p>

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1 CHAYTOR, Q.C.:
 2 Q. We skipped.
 3 THE COMMISSIONER:
 4 Q. -I had on a list but did not enter, so
 5 perhaps -
 6 CHAYTOR, Q.C.:
 7 Q. I think that might be it.
 8 THE COMMISSIONER:
 9 Q. Yes, all right then.
 10 CHAYTOR, Q.C.:
 11 Q. And then we have P-0700 through to P-0775
 12 inclusive.
 13 THE COMMISSIONER:
 14 Q. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. And also P-0486, P-0487 and P-0488.
 17 THE COMMISSIONER:
 18 Q. Okay, so that's P-0029 and 0031 or through
 19 0031, so inclusive, P-0700 through to P-0775
 20 and P-0486, 0487 and 0488 entered.
 21 EXHIBITS ENTERED AND MARKED P-0029, P-0030, P-0031
 22 EXHIBITS ENTERED AND MARKED P-0700 THROUGH P-0775
 23 EXHIBITS ENTERED AND MARKED P-0486, P-0487, P-0488
 24 CHAYTOR, Q.C.:
 25 Q. Thank you.

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1 MS. LOUISE JONES, SWORN, EXAMINATION BY SANDRA CHAYTOR,
 2 Q.C.
 3 REGISTRAR:
 4 Q. Would you please state and spell your complete
 5 name for the Commission?
 6 MS. JONES:
 7 A. Louise Jones, L-O-U-I-S-E J-O-N-E-S.
 8 REGISTRAR:
 9 Q. Thank you.
 10 CHAYTOR, Q.C.:
 11 Q. Thank you, Ms. Jones. Perhaps we can begin
 12 please by telling us your educational and
 13 professional background?
 14 MS. JONES:
 15 A. My background is nursing. I have a Bachelor
 16 of Nursing and a Masters of Business
 17 Administration from Memorial University. I
 18 also am a nursing fellow with Wharton School
 19 of Management in the University of
 20 Pennsylvania and I have a Certified Health
 21 Executive from the Canadian College of Health
 22 Services accreditation.
 23 CHAYTOR, Q.C.:
 24 Q. And when did you finish your Bachelor of
 25 Nursing?

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1 MS. JONES:
 2 A. 1976.
 3 CHAYTOR, Q.C.:
 4 Q. And your MBA?
 5 MS. JONES:
 6 A. 1990/91.
 7 CHAYTOR, Q.C.:
 8 Q. And what does it mean to be a nursing fellow?
 9 MS. JONES:
 10 A. It's a specialized program, residency program,
 11 short duration of six weeks in University of
 12 Pennsylvania.
 13 CHAYTOR, Q.C.:
 14 Q. And when did you complete that?
 15 MS. JONES:
 16 A. About 95/96 or so. That may not be the right
 17 years, but it's after my MBA.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, okay, and you're also, I'm sorry,
 20 certified -
 21 MS. JONES:
 22 A. Certified Health Executive with the Canadian
 23 College of Health Services, administrator.
 24 No, Canadian College of--yeah, Health Service
 25 Executives.

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1 CHAYTOR, Q.C.:
 2 Q. Okay, and what does that mean?
 3 MS. JONES:
 4 A. It really is, it's a designation that you can
 5 write exams and do assignments with respect to
 6 management, health service executive.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, and when did you achieve that?
 9 MS. JONES:
 10 A. That was in the 1990s as well.
 11 CHAYTOR, Q.C.:
 12 Q. And take us then through your professional
 13 background, up to your current position.
 14 MS. JONES:
 15 A. I had started in 1976 where I had a number of
 16 frontline nursing positions, in terms of staff
 17 nurse. I moved from there to management of
 18 frontline manager in dialysis and emergency.
 19 After that, I moved into staff education roles
 20 at St. Clare's Hospital, and from there, in
 21 1989, I moved into what would have been
 22 considered senior administration roles, first
 23 with the Grace Hospital as their director of
 24 nursing and then in 1995, with the coming
 25 together of the Health Care Corporation in St.

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<p>1 John's, I became the vice-president for 2 patient care services within that organization 3 from 1995 to 2005, and then in 2005, with the 4 start of Eastern Health, I came into Eastern 5 Health as a chief operating officer for adult 6 acute care in St. John's and that was in April 7 of 2005, and since July of this year, I've 8 taken on the interim role, president and CEO 9 for Eastern Health.</p> <p>10 CHAYTOR, Q.C.: 11 Q. July of 2007? 12 MS. JONES: 13 A. July of 2007. 14 CHAYTOR, Q.C.: 15 Q. Okay, so you were ten years as the VP of 16 patient care services? 17 MS. JONES: 18 A. Yes. 19 CHAYTOR, Q.C.: 20 Q. What did those duties involve? 21 MS. JONES: 22 A. Basically, in the Health Care Corporation of 23 St. John's, we were a program managed 24 organizations, so my portfolio throughout 25 those years had many of the clinical services,</p>	<p>1 structure where there was lab directorship and 2 so therefore, the lab people inside of the lab 3 program reported directly through to the 4 manager in that area. 5 CHAYTOR, Q.C.: 6 Q. Were you ever responsible for laboratory 7 medicine or laboratory services at all? 8 MS. JONES: 9 A. No. 10 CHAYTOR, Q.C.: 11 Q. And you were responsible as professional 12 practice for nurses? 13 MS. JONES: 14 A. Yes. 15 CHAYTOR, Q.C.: 16 Q. And at different points, you were responsible 17 for surgery, would have come under your 18 mandate? 19 MS. JONES: 20 A. Surgery, as a program, in terms of program 21 management, yes. 22 CHAYTOR, Q.C.: 23 Q. Okay, and if we could look at P-0043, please, 24 page one? 25 THE COMMISSIONER:</p>
Page 10	Page 12
<p>1 like the programs for critical care, emergency 2 medicine surgery and some of the other 3 programs from time to time, like 4 rehabilitation, as well as child health so at 5 various points in time. I also was 6 responsible for overseeing professional 7 practice, both on the nursing side and the 8 allied health side, and also through the 9 period of time in the early years, I had some 10 departmental responsibility where I oversaw 11 pharmacy and throughout the entire Health Care 12 Corporation, pastoral care and ethics reported 13 to me. 14 CHAYTOR, Q.C.: 15 Q. And overseeing professional practice for 16 allied health workers, would that include 17 laboratory technologists? 18 MS. JONES: 19 A. No. In program management, these--when we talk 20 about professional practice, what we did was 21 where in fact there was not a manager of a 22 particular area responsible like a nursing 23 manager responsible for nurses, we had a 24 professional practice structure in place, but 25 in the lab, the lab was a single management</p>	<p>1 Q. Documents will come up on the screen in front 2 of you, and I believe you have a paper copy. 3 REGISTRAR: 4 Q. Excuse me, Ms. Chaytor, what was the number? 5 CHAYTOR, Q.C.: 6 Q. 0043, please. 7 THE COMMISSIONER: 8 Q. I'm not sure, frankly if - 9 CHAYTOR, Q.C.: 10 Q. The paper copy is not there. 11 THE COMMISSIONER: 12 Q. - is 0043 in that paper copy? 13 REGISTRAR: 14 Q. 0043 won't be in that. 15 THE COMMISSIONER: 16 Q. All right. 17 CHAYTOR, Q.C.: 18 Q. It should be on your screen, Ms. Jones. 19 THE COMMISSIONER: 20 Q. Sorry, I mislead you. Now, P-0043. 21 CHAYTOR, Q.C.: 22 Q. Okay, so if we look at this document, page one 23 on the bottom is the date is May 15th, 2001. 24 MS. JONES: 25 A. That's right.</p>

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1 CHAYTOR, Q.C.:

2 Q. And we understand this is a flow chart for the

3 Health Care Corporation at the time.

4 MS. JONES:

5 A. Yes, it is.

6 CHAYTOR, Q.C.:

7 Q. And so your area would have been the second

8 column, VP patient care services?

9 MS. JONES:

10 A. That's right.

11 CHAYTOR, Q.C.:

12 Q. And as of that time anyhow, you were

13 responsible for surgery, medicine, critical

14 care, peri-operative, child health, women's

15 health, the Miller Centre, for nursing

16 studies, pastoral care, nursing services

17 development and the board committee that you

18 would sit on would be ethics and values?

19 MS. JONES:

20 A. That's right.

21 CHAYTOR, Q.C.:

22 Q. Okay. What's the peri-operative program?

23 MS. JONES:

24 A. Peri-operative is the operating rooms in St.

25 John's on the adult side. The children's

Page 14

1 program managed their own operating rooms, so

2 that would have been the operating rooms at

3 St. Clare's and the Health Sciences.

4 CHAYTOR, Q.C.:

5 Q. Okay. So that would have come under your

6 responsibility at this time?

7 MS. JONES:

8 A. That's right.

9 CHAYTOR, Q.C.:

10 Q. Okay, and then the next page, page two of this

11 exhibit, again we see vice-president patient

12 care services. So again, that would be you?

13 MS. JONES:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. The date on this document, it has been revised

17 as of July 19th, 2005.

18 MS. JONES:

19 A. Yes.

20 CHAYTOR, Q.C.:

21 Q. And you're responsible at this point in time

22 for child health, critical care medicine,

23 nursing service development, pastoral care,

24 peri-operative, rehabilitation, continuing

25 care, Centre for Nursing Studies, surgery, and

Page 15

1 women's health?

2 MS. JONES:

3 A. Yes.

4 CHAYTOR, Q.C.:

5 Q. Okay, and did it change after that? I guess,

6 we go to page three.

7 MS. JONES:

8 A. In that one, we combined programs. The Miller

9 Centre and the rehabilitation program were

10 combined into a single program at that point

11 in time.

12 CHAYTOR, Q.C.:

13 Q. Okay, and this flow chart shows that you--your

14 title is now changed. You're vice-president

15 adult acute care?

16 MS. JONES:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. And your name is indicated.

20 MS. JONES:

21 A. Yes.

22 CHAYTOR, Q.C.:

23 Q. And now you're surgery, emergency, ambulatory

24 care, still peri-operative, cardiac critical

25 care, medicine, Centre for Nursing Studies,

Page 16

1 nursing service development, still pastoral

2 care?

3 MS. JONES:

4 A. Yes.

5 CHAYTOR, Q.C.:

6 Q. And still the board committee that you're

7 involved with is ethics and values?

8 MS. JONES:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. And the date on--I don't think there's a date.

12 MS. JONES:

13 A. Yes.

14 CHAYTOR, Q.C.:

15 Q. Revised June '04, up in the top left corner.

16 MS. JONES:

17 A. That's right.

18 CHAYTOR, Q.C.:

19 Q. And is that the situation then you stayed

20 responsible for those areas until April 2005,

21 when you became COO?

22 MS. JONES:

23 A. I would think so. We moved programs around

24 from time to time, depending on what their

25 issues were or where the expertise was, but

Page 17

1 that likely in June of 2004 would have been
 2 the portfolio that I ended with as we went in
 3 in April of 2005 to Eastern Health.
 4 CHAYTOR, Q.C.:
 5 Q. And what did it mean to be responsible for the
 6 professional practice of nurses?
 7 MS. JONES:
 8 A. We have a structure in place where we have a
 9 professional practice coordinators and
 10 councils, where we have staff come together in
 11 terms of, in this instance, nursing councils.
 12 They're responsible for standards and research
 13 in nursing, those kinds of things. So it was
 14 bringing together-- inside a program
 15 management structure, there isn't a direct
 16 line relationship for nurses reporting to
 17 nurses up through the old structures like
 18 directors of nursing. So what would happen is
 19 that we put a parallel structure for
 20 professional practice, not only for nurses,
 21 but for physios, OTs, social workers, and
 22 there's a number of other areas in there as
 23 well. So basically, for the standards and
 24 research, those kinds of things.
 25 CHAYTOR, Q.C.:

Page 18

1 Q. So if there's continuing education for the
 2 nurses -
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. - would that come under what you were doing?
 7 MS. JONES:
 8 A. No, not necessarily, because we have human
 9 resources, and if you go across there, you see
 10 underneath Steve Dodge, organization
 11 development.
 12 CHAYTOR, Q.C.:
 13 Q. Yes.
 14 MS. JONES:
 15 A. From time to time, throughout the Health Care
 16 Corporation, what we had done was we had
 17 pulled together all of the education
 18 resources, whether they were general education
 19 or professional education like nurse educators
 20 into a single department. At some point in
 21 time, in the Health Care Corporation, we put
 22 the educators for like nurses, because we had
 23 a fair amount of nursing education, back into
 24 the program. So there would be a surgery
 25 educator inside of surgery, okay. What would

Page 19

1 happen inside of the nursing service
 2 development is that they were more responsible
 3 for the education on standards and the more
 4 generic pieces, rather than the individual
 5 education of nurses. So they would coordinate
 6 the bigger pieces and were responsible for,
 7 you know, sending people out to the
 8 Association of Registered Nurses, through
 9 their annual meetings, those kinds of things,
 10 and if there were bigger pieces like medical
 11 legal or ethics or things like that, then
 12 nursing service development would coordinate
 13 that and offer it for the entire organization.
 14 CHAYTOR, Q.C.:
 15 Q. But if there were to be a new standard then
 16 adopted within the hospital, which would
 17 relate to how they do their job, that would
 18 come under what you're doing?
 19 MS. JONES:
 20 A. That would come under nursing service
 21 development because they had the
 22 responsibility for policy and procedure in the
 23 generic sense, but when it came to individual
 24 program area, like expertise in peri-operative
 25 or surgery, then that would happen at the

Page 20

1 program director level. So we had a stage, if
 2 it was very specific in a particular area that
 3 only involved surgery but didn't involve
 4 medicine or emergency, then it was the
 5 leadership within the surgery or the peri-
 6 operative area, whatever it crossed over.
 7 Then when we had general standards of nursing,
 8 that would apply to all areas. That's where
 9 the professional practice council would sign
 10 off and the professional practice coordinators
 11 would be, in fact, responsible for updating
 12 those on a regular basis.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. Then if we look at, please, P-0044?
 15 REGISTRAR:
 16 Q. Sorry, what was that again?
 17 CHAYTOR, Q.C.:
 18 Q. P-0044. Okay, we see your name here. This is
 19 a flow chart for the Eastern Regional
 20 Integrated Health Authority.
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And the date on the document is in the top
 25 left corner, and it's a little bit -

Page 21

1 MS. JONES:
 2 A. It's 2006.
 3 CHAYTOR, Q.C.:
 4 Q. - missing, but I think it's November -
 5 MS. JONES:
 6 A. 22nd, 2006, yes.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. I take it though that this was the
 9 document or this was the arrangement, the
 10 organization that came into being in April of
 11 2005?
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. It's revised somewhat though, I guess,
 16 in November of 2006, but if we could -
 17 MS. JONES:
 18 A. That revision would have been because Dr.
 19 Williams had left the organization and Dr.
 20 Howell had come into the organization and
 21 there was a realignment of quality and risk
 22 management out of the VP medical service and
 23 diagnostics portfolio into Pat Pilgrim's
 24 portfolio. That was the major change there.
 25 CHAYTOR, Q.C.:

Page 22

1 Q. Okay. So other than that, it's pretty much
 2 what it was when the organization -
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. - came into being in April 2005, and in
 7 particular, if we look at -
 8 MS. JONES:
 9 A. The other thing though, there were some
 10 changes in Alice Kennedy's portfolio.
 11 Initially, she had started off with long-term
 12 care and then very early along, we moved
 13 community living and supportive services. So
 14 as the organization started to develop and put
 15 its organization structure in place, there
 16 were better alignments across various
 17 individuals. So Alice would have been hired
 18 for long-term care, but very early, probably
 19 by the fall of 2005, long-term care and
 20 supportive services would have been moved into
 21 that portfolio. Community living and
 22 supportive services would have been moved into
 23 that portfolio, out of Bev Clarke's portfolio.
 24 CHAYTOR, Q.C.:
 25 Q. Okay then, all right, and your own duties, at

Page 23

1 this point, you're COO of adult acute care?
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. In St. John's. Where was your office?
 6 MS. JONES:
 7 A. My office for the majority of the time I spent
 8 in the Health Care Corporation as well as the
 9 time, except for the last few months, has been
 10 at St. Clare's.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, and where's your office now?
 13 MS. JONES:
 14 A. My office is at corporate office on Waterford
 15 Bridge Road.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. So throughout the time that you were VP
 18 and then COO, you were primarily located at
 19 St. Clare's?
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. Okay, and this indicates that your duties as
 24 COO of adult acute care are cardiac critical,
 25 clinical efficiency, emergency, ambulatory,

Page 24

1 emergency medical services, medicine, pastoral
 2 care ethics, peri-operative and surgery?
 3 MS. JONES:
 4 A. That's right.
 5 CHAYTOR, Q.C.:
 6 Q. So the pastoral care ethics, peri-operative
 7 and surgery, those have remained your
 8 portfolio since back in 1995?
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. Yes, okay. The other people on the flow
 13 chart, Pat Coish-Snow.
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. She's operating officer Peninsulas. Where is
 18 she located?
 19 MS. JONES:
 20 A. She's located in Clarendville.
 21 CHAYTOR, Q.C.:
 22 Q. And Faye Matthews?
 23 MS. JONES:
 24 A. In Whitbourne.
 25 CHAYTOR, Q.C.:

Page 25

1 Q. Alice Kennedy?
 2 MS. JONES:
 3 A. At St. Pat's here in St. John's.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, and you're, at this point in time,
 6 according to the flow chart, you're still at
 7 St. Clare's?
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. And where would Pat Pilgrim be?
 12 MS. JONES:
 13 A. Health Sciences.
 14 CHAYTOR, Q.C.:
 15 Q. And Beverly Clarke?
 16 MS. JONES:
 17 A. At this point in time, she was at Cordage
 18 Place in St. John's.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, and I guess I should have started with
 21 the CEO at the top, would have been at
 22 Waterford Bridge Road?
 23 MS. JONES:
 24 A. That's right.
 25 CHAYTOR, Q.C.:

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1 Q. George Butt, where would he have been?
 2 MS. JONES:
 3 A. He's in Carbonear.
 4 CHAYTOR, Q.C.:
 5 Q. And Stephen Dodge?
 6 MS. JONES:
 7 A. He's at corporate office on Waterford Bridge
 8 Road in St. John's.
 9 CHAYTOR, Q.C.:
 10 Q. And Oscar Howell?
 11 MS. JONES:
 12 A. He's at the Health Sciences.
 13 CHAYTOR, Q.C.:
 14 Q. And Wayne Miller?
 15 MS. JONES:
 16 A. Wayne Miller is located out of corporate
 17 office on Waterford Bridge Road.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, and what's the current situation? Which
 20 of these people have changed from those
 21 locations?
 22 MS. JONES:
 23 A. I've changed and Bev Clarke is now working out
 24 of what I would call Sobey's Square in on
 25 Topsail Road, moved from Cordage Place there

Page 27

1 to a new rental property.
 2 CHAYTOR, Q.C.:
 3 Q. Her position is the same though, is it?
 4 MS. JONES:
 5 A. Her position's the same, and in my role, Norma
 6 Baker is now sitting in that role and she
 7 works out of St. Clare's.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. So while you were chief operating
 10 officer of adult acute care, did you have
 11 responsibility for any particular site? I
 12 know you were operating out of St. Clare's, or
 13 that's where your office was, but were you
 14 responsible for all the hospitals in St.
 15 John's?
 16 MS. JONES:
 17 A. The -
 18 CHAYTOR, Q.C.:
 19 Q. All the adult hospitals?
 20 MS. JONES:
 21 A. We don't do it in terms of the clinical
 22 services that are associated with that
 23 portfolio mainly work out of Health Sciences
 24 and St. Clare's. So it's the clinical service
 25 component, but it isn't responsibility for St.

Page 28

1 Clare's as a hospital and it's not
 2 responsibility for the Health Sciences as a
 3 hospital. What I will say to you is--and you
 4 would have seen it in an earlier
 5 organizational chart, I also, in this
 6 particular role at St. Clare's, was the
 7 liaison person with the Sisters of Mercy,
 8 where they have an agreement with the
 9 Government of Newfoundland and Labrador from
 10 pre-1995 where there is an on-site
 11 administrator that is called in their
 12 agreement. So I am the person responsible on
 13 that site for values and ethics in line with
 14 the tradition, the Catholic tradition. So
 15 that's the St. Clare's Advisory committee and
 16 there are terms of reference. There's an
 17 agreement with the government, but it's only
 18 in relation to ethics and values.
 19 CHAYTOR, Q.C.:
 20 Q. And you would have carried out that role, that
 21 liaison role, the whole time you were COO?
 22 MS. JONES:
 23 A. And I continue to carry that liaison role as
 24 the president as well.
 25 CHAYTOR, Q.C.:

Page 29

1 Q. You still do?
 2 MS. JONES:
 3 A. I still do.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. You indicated that you were never
 6 responsible for laboratory services.
 7 MS. JONES:
 8 A. That's right.
 9 CHAYTOR, Q.C.:
 10 Q. How does or how did the adult acute care
 11 portfolio then relate to the laboratory
 12 medicine program?
 13 MS. JONES:
 14 A. It would have related on, mostly on the
 15 program directors would have had relationships
 16 and they would have discussed issues that they
 17 may very well have had and through the
 18 executive team of Eastern Health or the old
 19 Health Care Corporation of St. John's, if
 20 there were issues between one program and
 21 another around policy or anything that
 22 couldn't be resolved at the program director
 23 level, then it would have been elevated to the
 24 executive team.
 25 CHAYTOR, Q.C.:

Page 30

1 Q. Did anybody from the laboratory medicine
 2 program ever speak to you in your role as COO
 3 concerning issues of ER/PR or IHC in general?
 4 MS. JONES:
 5 A. Not in that, more of a supportive role. Don
 6 Cook would have--who was the clinical chief,
 7 may have had conversations with me, but not
 8 really around ER/PR or anything, just about
 9 what was going on in the organization and how
 10 they were feeling about it and how they were
 11 moving forward in terms of addressing issues,
 12 but not from a decision maker or even--it was
 13 more of a support role, supportive of the
 14 individuals versus the actual day-to-day
 15 operations and what was going on inside.
 16 CHAYTOR, Q.C.:
 17 Q. So no engagement of you in your official
 18 capacity?
 19 MS. JONES:
 20 A. No engagement in the official capacity.
 21 CHAYTOR, Q.C.:
 22 Q. Okay, and prior to--I take it from your answer
 23 that you're answering post spring of 2005.
 24 But prior to that time, did anyone ever
 25 approach you or discuss with you any issues

Page 31

1 concerning ER/PR or IHC in general?
 2 MS. JONES:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. What did it mean to have responsibility for
 6 the peri-operative program?
 7 MS. JONES:
 8 A. The peri-operative program has a program
 9 leadership team that has a program director, a
 10 clinical chief. Actually, in peri-operative,
 11 there are two clinical chiefs. There is what
 12 we call co-clinical chiefs. So there would be
 13 one who has or works in the surgical area as a
 14 surgeon and an anesthetist. So that's one of
 15 the areas where we have two physician leaders,
 16 as well as a director. On at least a monthly
 17 basis or so, I would meet with the program
 18 director and we would discuss issues that were
 19 going on, what we needed to resolve, where the
 20 program was going, budget issues, staffing
 21 issues, anything that was going on in the
 22 program. Occasionally, the whole leadership
 23 team, I would meet with the whole leadership
 24 team as well, which included the physicians,
 25 just as touch points throughout the year, and

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1 I also met and I had a practice of meeting
 2 maybe two or three times a year with all of
 3 the managers in every one of the programs. So
 4 in the peri-operative program, there are three
 5 managers. So as a management team, I would
 6 have met with the divisional managers, we
 7 called them at the time, and the program
 8 director, just to hear their concerns or what
 9 issues were facing them and where they were
 10 going and how they were trying to resolve
 11 them.
 12 CHAYTOR, Q.C.:
 13 Q. And were any concerns ever brought to your
 14 attention regarding their role and how it
 15 relates to laboratory medicine program?
 16 MS. JONES:
 17 A. Not that I can recall.
 18 CHAYTOR, Q.C.:
 19 Q. And if there were to be policies developed as
 20 to how people in the peri-operative program
 21 carry out their job?
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. What level, who would be responsible for the

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1 development and implementation of those
 2 policies?
 3 MS. JONES:
 4 A. Because peri-operative is a very specialized
 5 area not likely to cross over into other
 6 nursing realms that the responsibility for the
 7 development of policy in that area would have
 8 been left with the division managers as well
 9 as the program director. And the program
 10 director would have signed off on policies
 11 inside of their own manuals related to the
 12 particular work that was going on in that
 13 area.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And the division manager would be the
 16 physician?
 17 MS. JONES:
 18 A. No. The division manager would be the front-
 19 line manager for each one of the operating
 20 rooms as well as recovery room, because in
 21 peri-operative it has the surgical daycare,
 22 the recovery room, the operating rooms and the
 23 pre-admission clinics.
 24 CHAYTOR, Q.C.:
 25 Q. And so would the physicians involved also,

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1 though, involved in the program, have to sign
 2 off on any policies?
 3 MS. JONES:
 4 A. Not if it was a nursing policy, okay. They
 5 may very well have been involved in the
 6 discussions about what it was, particularly if
 7 we were talking about preparation for
 8 operating room, the types of solutions you
 9 would need, those kinds of things, so they
 10 would have discussion around that. But the
 11 policies generally were nursing policies.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. And your responsibility for pastoral
 14 care and ethics.
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. What did that mean, to be responsible for
 19 pastoral care and ethics?
 20 MS. JONES:
 21 A. In the same vein, pastoral care and ethics,
 22 the majority of the individuals that we have
 23 that work in pastoral care and ethics are
 24 volunteers. We have a small cadre of paid
 25 staff, probably only in the tune of five or

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1 six. And that particular staff, the director,
 2 since 1995, has been Dr. Rick Singleton, has
 3 really been responsible for nurturing pastoral
 4 care, respecting all of the various religions
 5 in this province and then working on various
 6 levels of interaction with patients. So from
 7 the pastoral care side we have a significant
 8 number of volunteers that are coordinated
 9 through pastoral care. We have, as I said, a
 10 small cadre of individuals that visit clients
 11 that maybe do not have a religious
 12 affiliation. And then on the ethics side this
 13 particular department has been the department
 14 that has been responsible for leading a lot of
 15 the ethics work. We have a liaison, we
 16 contract with Memorial University for ethics
 17 resource and, in fact, we have a contract that
 18 has been in place since probably '96 or '97
 19 that we've expanded over time where we use an
 20 ethics structure, not necessary--ethics
 21 consultation is not done by a single
 22 individual, it's done by a group. We have a
 23 whole very formal process of a number of
 24 trained facilitators that we've internally
 25 trained using the resources from the

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1 university as well as organizational
 2 development. We've trained facilitators. And
 3 when we get an ethics consult or we get a
 4 request for an ethics consult, we bring a
 5 facilitator in to tease out the ethics
 6 question, because lots of times it's not
 7 really an ethics question, it's really
 8 complete (phonetic) maybe staff complete,
 9 maybe there needs to be some pre work done, so
 10 that's fairly well articulated. We bring
 11 together a group of individuals that are
 12 familiar with the issue, maybe includes the
 13 patient, maybe it doesn't, depends on what the
 14 issue is. And then we move the issue forward
 15 with recommendations. Ethics inside of the
 16 Health Care Corporation and as well moving
 17 into Eastern Health included not just clinical
 18 ethics, but it included administrative ethics,
 19 as well, so that's everything from food
 20 choices to lottery, to gambling, those kinds
 21 of things. So we had broadened much further
 22 than just clinical ethics into all areas of
 23 ethics inside of Eastern Health and that's
 24 what pastoral care and ethics in--when we came
 25 together in Eastern Health, we named it as

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1 pastoral care and ethics. In the old Health
 2 Care Corporation of St. John's it was only the
 3 pastoral care department, but they had
 4 responsibility for ethics, it was not in their
 5 name, but they still put all of the structures
 6 in place and maintained the structures as we
 7 moved forward.

8 CHAYTOR, Q.C.:

9 Q. Okay. And so your role in all of that, if
 10 there were to be an ethical consult requested,
 11 does that come in through you?

12 MS. JONES:

13 A. Any ethics consult, my previous, my chief
 14 operating officer's secretary, okay, she would
 15 receive consults, okay, and -

16 CHAYTOR, Q.C.:

17 Q. So it would come in to your office as chief
 18 operating officer -

19 MS. JONES:

20 A. Would come in to the office rather than in to
 21 me.

22 CHAYTOR, Q.C.:

23 Q. Yes.

24 MS. JONES:

25 A. And all she would do is identify a

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1 facilitator, pass it on to the facilitator and
 2 then we were the place that housed all of the
 3 ethics reports, okay. So that on a yearly
 4 basis we then generated a list of the number
 5 of ethical consults that we had in the run of
 6 the year, the type of issue and then we would
 7 review them in terms of the regional ethics
 8 committee, it would have been called basically
 9 that throughout the entire period of time. We
 10 would review the types of consults to
 11 determine whether, in fact, there was need to
 12 develop some policy direction in certain
 13 areas. And we would review them on a yearly
 14 basis to see where the trends were and the
 15 work that we needed to continue to work on or
 16 to review, if we had some policies in a
 17 particular area, because they were either in
 18 conflict or there were things that were coming
 19 through the ethics consults.

20 CHAYTOR, Q.C.:

21 Q. So when the consult came in, you may not even
 22 be aware that a consult came in?

23 MS. JONES:

24 A. Not unless--unless there was a particular
 25 request that it needed to be pushed fast and I

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1 might need to assist my secretary to identify
 2 a facilitator. Normally we would have worked
 3 through Rick Singleton, if he wasn't around at
 4 the time, because the facilitators were inside
 5 of Eastern Health. We always had an ethicist
 6 who worked with a consult, but it was maybe
 7 sometimes helping her to say which facilitator
 8 can we access really quickly and to make those
 9 kinds of things happen.

10 CHAYTOR, Q.C.:

11 Q. Okay. So the consult would come in and your
 12 assistant would deal with it in terms of -

13 MS. JONES:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. - finding a facilitator?

17 MS. JONES:

18 A. Yeah.

19 CHAYTOR, Q.C.:

20 Q. When the report is generated, would you see
 21 that?

22 MS. JONES:

23 A. No, not necessarily, unless it was
 24 specifically sent to me saying--and I will
 25 reference the one that I know that you're

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1 going at, which was in June of 2006. There
 2 was an ethic consult requested around the
 3 clients who had died in the ER/PR and Dr.
 4 Williams had called me to say, "I need an
 5 ethics consult on that. Can you get Rick on
 6 that right away?"

7 CHAYTOR, Q.C.:

8 Q. Okay.

9 MS. JONES:

10 A. So I would have made a phone call to Rick to
 11 say, "This is important. We need to action
 12 it." And then when it was finished, he would
 13 have sent the report to me back to say,
 14 "Louise, this is done now." That's how -

15 CHAYTOR, Q.C.:

16 Q. And I'll ask you some details about that
 17 later.

18 MS. JONES:

19 A. Yeah, that's right.

20 CHAYTOR, Q.C.:

21 Q. So in that particular situation you did have
 22 personal contact?

23 MS. JONES:

24 A. That's right.

25 CHAYTOR, Q.C.:

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1 Q. You were contacted directly by Dr. Williams?
 2 MS. JONES:
 3 A. Yeah.
 4 CHAYTOR, Q.C.:
 5 Q. But the norm was that it would come in through
 6 your assistant?
 7 MS. JONES:
 8 A. Yeah. And the only other, what you'll hear is
 9 sometimes a facilitator, normally maybe Rick,
 10 Dr. Rick Singleton, but there may have been
 11 other facilitators who may have called
 12 occasionally to say "What kind of individuals
 13 do you believe we need around a consult on A?"
 14 And I would say, "You'll have to talk to the
 15 people in the area, but I would suggest that
 16 you bring in, you know, the discipline of
 17 physio," or "medicine" or whatever. So it
 18 wasn't directing the consult, it was maybe
 19 helping the facilitator identify the type of
 20 individual, not the actual individual and then
 21 working with the group to identify who else
 22 needed to be in on the consults.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. All right. And I'll come back to that
 25 afterwards when we deal specifically with this

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1 consult.
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Did you--in terms then of tracking trends at
 6 the end of the day -
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. - you said that part of what you would do is
 11 sit down at the end of the day and review any
 12 ethical consults that had happened that year?
 13 MS. JONES:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. What would that involve? And you say "we", is
 17 there a committee or who would do that?
 18 MS. JONES:
 19 A. Well, usually Dr. Singleton and my secretary
 20 would sit and say, "that was on competency" or
 21 "this was on decision to treat," or whatever
 22 in terms of teasing out what the main area of
 23 the consult was, not the outcome of the
 24 consult, just the theme. And so occasionally
 25 as my secretary would be working on that,

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1 she'd say, "Louise, you know, this appears to
 2 be this theme," and then we would generate
 3 only a maybe two or three-page report, we
 4 wouldn't list them all out, we would say we
 5 had five consults in the area of competency,
 6 we'd--and the various areas, and it just
 7 eludes me now what they might have been. And
 8 then at the end of the day we would bring
 9 forward and have discussion inside of the
 10 regional ethics committee to say, "Look, these
 11 are the things that we're seeing here. What
 12 is the implication?" It may have been
 13 education on a particular policy, it may be we
 14 need to revise a particular policy, but it
 15 would have been what we would have had was a
 16 regional ethics committee that we first would
 17 have gone to the facilitators, we would bring
 18 them together on a yearly basis to look at the
 19 report that we had generated. They were the
 20 individuals who'd ran the consults, what the
 21 issues were, do we need to change process and
 22 from their perspective was the there any
 23 follow-up that we needed to do and any work
 24 that would need to flow out of it.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And the issue, of course, that was sent
 2 for an ethical consult in this case was an
 3 issue around disclosure of information.
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Had you noticed any trend in issues of
 8 disclosure prior to the consult, this consult
 9 being done in the middle of 2006?
 10 MS. JONES:
 11 A. Not really. But what we had done in the
 12 previous Health Care Corporation as we came
 13 into Eastern Health disclosure was an issue.
 14 So the ethics committee, working with quality
 15 on that, had done a lot of work around private
 16 disclosure, okay. Not the issue of public
 17 disclosure. So we had a policy developed in
 18 the latter part of the old Health Care
 19 Corporation of St. John's which dealt with
 20 disclosure using the evidence base, what was
 21 out there at the time. So the ethics
 22 committee had worked with that because
 23 disclosure in terms of the general public and
 24 the health care environment was becoming a big
 25 issue and Canadian Patient Safety Institute

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1 was on the issue of disclosure, plus the
 2 Canadian Council on Health Services
 3 Accreditation was looking for policy direction
 4 on disclosure. In the past we had used maybe
 5 public statements from the Canadian Nurses
 6 Association or the Canadian Medical
 7 Association, but we hadn't actually adopted a
 8 disclosure policy inside the organization. So
 9 there was a lot of time and energy spent in
 10 developing that particular policy statement
 11 with a lot of ethics input into it at the
 12 time.
 13 CHAYTOR, Q.C.:
 14 Q. And those are the policies, of course, that
 15 we've seen here in the -
 16 MS. JONES:
 17 A. That's right.
 18 CHAYTOR, Q.C.:
 19 Q. - course of the Inquiry?
 20 MS. JONES:
 21 A. Yeah.
 22 CHAYTOR, Q.C.:
 23 Q. Tell us then a bit about your current
 24 position? You took over as acting interim
 25 CEO. When exactly was that?

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1 MS. JONES:
 2 A. 9th of July, 7:30 in the morning.
 3 CHAYTOR, Q.C.:
 4 Q. And how did that come to be?
 5 MS. JONES:
 6 A. I had gotten a call from the chair on the
 7 Sunday, so that would have been the 8th of
 8 July. I wasn't in town at the time and we
 9 didn't connect until somewhere around 11:30
 10 that night, and she wanted to have a
 11 discussion with me at 7:30 the next morning.
 12 So when I arrived at work the 7:30 the next
 13 morning, the vice chair and the chair had
 14 indicated that Mr. Tilley had resigned and
 15 they asked if I would take on the interim
 16 president and CEO role.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And you agreed to do that that morning?
 19 MS. JONES:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. And were there any--were you given any
 23 description as to what would be expected of
 24 you, how was your job defined for you?
 25 MS. JONES:

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1 A. Well, there is a contract that there is with
 2 the organization, so I was aware that
 3 basically I would take on this interim role
 4 until they recruited their permanent CEO. We
 5 had had the discussion that that would not
 6 happen inside of six or nine months, probably
 7 close to a year by the time they got out and
 8 advertised, that I would take on the full
 9 duties and responsibilities. I had indicated
 10 at the--there was the issue of the Burin
 11 radiology, preparing for the Commission of
 12 Inquiry, and whatever support I needed to move
 13 those particular issues and to move the
 14 organization forward, that I would have their
 15 full support and basically we started at 8:30
 16 that morning.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. And in terms of your--who do you report
 19 to?
 20 MS. JONES:
 21 A. I report to Joan Dawe.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And who is your liaison or contact at
 24 the Department of Health and Community
 25 Services?

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1 MS. JONES:
 2 A. Would be the deputy minister, currently Don
 3 Keats.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. And prior to Keats taking his position?
 6 MS. JONES:
 7 A. It was Robert Thompson.
 8 CHAYTOR, Q.C.:
 9 Q. And I'll come back to that a little later on
 10 in terms of any discussions you've had with
 11 the department and your current relationship
 12 with the department.
 13 MS. JONES:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. Let's talk about the issue then at hand. When
 17 did you first hear that there was such an
 18 issue as ER/PR?
 19 MS. JONES:
 20 A. It's difficult to kind of put an exact time
 21 line on it, but it would have been as we were
 22 going into the summer of 2005. You know,
 23 whether it was June, July or whatever, it's--I
 24 can't say, but it would have been as we were
 25 going into the summer. And it was really just

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1 that there was an issue in the lab. At the
 2 time it was a discussion that there was an
 3 individual client who they were looking for
 4 treatment options on and there was a question
 5 around the ER/PR result and the result being
 6 different on retest than it was originally.
 7 And then during the summer of 2005,
 8 remembering that Eastern Health only came
 9 together in April, and in the summer we don't
 10 come together, we would have only heard that
 11 as an executive because we come together like
 12 every two weeks or so, we would have been
 13 updated about what was going on. Plus we were
 14 putting organizational structures in place, we
 15 were going around the region, so there were
 16 very little executive committee meetings
 17 through the summer. And then we would have,
 18 when we came back in the fall, in September,
 19 we would have then heard a little bit more
 20 about it.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. And who did you hear about the patient,
 23 who did you hear about the patient who had
 24 some conflict in her ER result?
 25 MS. JONES:

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1 A. It's--I can't put an exact, but it may have
 2 been in a conversation inside of an executive
 3 team to say that "We have an issue, we have
 4 DAKO and we have Ventana," at that point in
 5 time it was two machines. I now know that
 6 they were DAKO and Ventana. We were looking
 7 to see if there was an issue with the machine
 8 because it was a relatively new one. But the--
 9 -what we would have called the sentinel event
 10 was that the physicians in--the oncologists
 11 were looking for a treatment option and in
 12 identifying a treatment option there was a
 13 change in a result of an ER/PR score.
 14 CHAYTOR, Q.C.:
 15 Q. Okay.
 16 MS. JONES:
 17 A. And so all of the things that happened through
 18 the summer of 2005, we would never have been
 19 aware of.
 20 CHAYTOR, Q.C.:
 21 Q. You wouldn't have been aware of that?
 22 MS. JONES:
 23 A. No.
 24 CHAYTOR, Q.C.:
 25 Q. So it would have come to your attention that

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1 there was a particular patient?
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Who had had a change in her ER result?
 6 MS. JONES:
 7 A. In score.
 8 CHAYTOR, Q.C.:
 9 Q. And do you recall who told you that?
 10 MS. JONES:
 11 A. No.
 12 CHAYTOR, Q.C.:
 13 Q. No. Was it Dr. Bob -
 14 MS. JONES:
 15 A. It probably was probably in a group
 16 discussion, right. So -
 17 CHAYTOR, Q.C.:
 18 Q. Was it Dr. Williams?
 19 MS. JONES:
 20 A. I can't say for sure.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. So that would have come out of a group
 23 discussion that there was a patient?
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:
 2 Q. And would that be the norm that it would be
 3 discussed if there was--I mean, there must be
 4 a lot of instances in a hospital where there's
 5 some change in treatment for a patient. Why
 6 would that have been the subject of discussion
 7 amongst a group?
 8 MS. JONES:
 9 A. Because what we were talking about was the
 10 technology as well as need--going back and at
 11 the end of the day finding out what was going
 12 on, okay. So this was a bigger issue than
 13 just one patient, right.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. So at the time that you're hearing
 16 about it, you know that it's more than one
 17 patient involved?
 18 MS. JONES:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. So there had been other testing done, I take
 22 it?
 23 MS. JONES:
 24 A. That's right.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And ever whose telling you this, what--
 2 who would the group be, then, do you recall,
 3 who else would have been there?
 4 MS. JONES:
 5 A. Well, the group would have been the executive,
 6 because that is the only time that we would
 7 have come together. The likelihood of myself
 8 having individual meetings with Bob Williams,
 9 unless it was on an issue that he had
 10 identified or that we needed to discuss, was
 11 minimal, right. We did most of our work
 12 through executive, okay, if there were issues
 13 that needed to be resolved. And at that point
 14 in time you have to remember that the Health
 15 Care--that Eastern Health was just coming to
 16 being. We were doing, even in May and June,
 17 all the way through May and June we were going
 18 all throughout the region seeing Bonavista and
 19 Burin and all of the sites and getting a
 20 handle because we'd only been as an executive
 21 team in place for less than two or three
 22 months. So we were getting a handle on the
 23 scope of--even though we had our own
 24 individual portfolios, in my instance the
 25 portfolio that I had I was quite used to

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1 because it essentially was a portfolio that I
 2 had brought forward from the old Health Care
 3 Corporation of St. John's. Many of the other
 4 chief operating officers and even the VPs,
 5 their portfolios were vastly different than
 6 what they would have had in the past. So it
 7 really was an opportunity for us to move
 8 through the region, to see all of the sites,
 9 to see all of the services and then to talk
 10 about organizational structure. So a lot of
 11 the initial work that we were doing was how am
 12 I going to set up my portfolio on a regional
 13 basis and those kinds of things.
 14 CHAYTOR, Q.C.:
 15 Q. Right, okay. I just want to focus in, though.
 16 The question that I'm wondering about is when
 17 you learned about ER/PR, what you were told,
 18 who was in the room, and -
 19 MS. JONES:
 20 A. Can't tell you that, Ms. Chaytor.
 21 CHAYTOR, Q.C.:
 22 Q. So you have no recollection as to who told you
 23 and who else was present when you were told?
 24 MS. JONES:
 25 A. No. And it would have--like I say, most

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1 likely would have been that entire executive
 2 team who would have been in a every two-week
 3 meeting.
 4 CHAYTOR, Q.C.:
 5 Q. So you think it came up in a meeting?
 6 MS. JONES:
 7 A. In a meeting.
 8 CHAYTOR, Q.C.:
 9 Q. And would you expect that if that were the
 10 case that it would be reflected in the minutes
 11 of the meeting?
 12 MS. JONES:
 13 A. Remember at this point in time, though, we
 14 were doing a lot of touring around, okay. So
 15 whether it's a meeting or whether it's
 16 conversations that we're having while we're on
 17 tour is -
 18 CHAYTOR, Q.C.:
 19 Q. But if it came up in an official meeting,
 20 would you expect -
 21 MS. JONES:
 22 A. It would have been.
 23 CHAYTOR, Q.C.:
 24 Q. - it to be reflected in the minutes?
 25 MS. JONES:

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1 A. Yeah, in the minutes of an official meeting.
 2 CHAYTOR, Q.C.:
 3 Q. Right, okay. So you think it came up, though,
 4 in the context of conversation, if not in the
 5 context of an official meeting with the
 6 executive team?
 7 MS. JONES:
 8 A. That's right.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. But you don't recall who brought the
 11 issue forward?
 12 MS. JONES:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. And you can't say -
 16 MS. JONES:
 17 A. And I would anticipate that that issue would
 18 have been brought forward by Dr. Williams just
 19 to say, "We have an issue in the lab," right,
 20 "and that we are moving forward with finding
 21 out what's going on."
 22 CHAYTOR, Q.C.:
 23 Q. Yes. And what you were told in terms of the
 24 scope of the problem at the time was that
 25 there had been a patient?

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And there was some issue of the two machines?
 5 MS. JONES:
 6 A. We were thinking, they were thinking that it
 7 was the DAKO v. the Ventana.
 8 CHAYTOR, Q.C.:
 9 Q. Okay.
 10 MS. JONES:
 11 A. At the time.
 12 CHAYTOR, Q.C.:
 13 Q. At that particular time?
 14 MS. JONES:
 15 A. At that particular time.
 16 CHAYTOR, Q.C.:
 17 Q. And that there was an issue to be investigated
 18 so it had to have involved more than the one
 19 patient?
 20 MS. JONES:
 21 A. And at the end of the day, that investigation
 22 would have happened inside the lab, so until
 23 the investigation was done and there was
 24 something to report, that would have been--
 25 there would have been no other involvement of

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1 executive.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, and this happened, this conversation,
 4 sometime June or July of 2005?
 5 MS. JONES:
 6 A. Yes, sometime around the summer of 2005.
 7 CHAYTOR, Q.C.:
 8 Q. At any point prior to that, had anything come
 9 to the executive management committee in terms
 10 of similar issues with the laboratory?
 11 MS. JONES:
 12 A. No.
 13 CHAYTOR, Q.C.:
 14 Q. Had the issue that we know of regarding Dr.
 15 Ejeckam in 2003, had that ever been discussed
 16 at the executive management level?
 17 MS. JONES:
 18 A. No.
 19 CHAYTOR, Q.C.:
 20 Q. Were you otherwise aware of that, yourself?
 21 Had you heard of Dr. Ejeckam and the 2003
 22 issue?
 23 MS. JONES:
 24 A. I would not have had any knowledge of what was
 25 going on inside of the lab and I didn't even

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1 know that there was a Dr. Ejeckam, so -
 2 CHAYTOR, Q.C.:
 3 Q. So the first time you hear of Dr. Ejeckam is
 4 where?
 5 MS. JONES:
 6 A. Is when the premier holds the letter up in the
 7 House.
 8 CHAYTOR, Q.C.:
 9 Q. So may of 2007?
 10 MS. JONES:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. When you were told about the ER/PR issue, who
 14 did you understand was taking charge of the
 15 issue?
 16 MS. JONES:
 17 A. Dr. Williams. And that would have been
 18 anticipated because it was his program area,
 19 so he would have taken the lead on this,
 20 having it investigated and dealing with the
 21 issue as it was evolving.
 22 CHAYTOR, Q.C.:
 23 Q. And I take it at that point in time your
 24 portfolio wasn't brought into the group?
 25 MS. JONES:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. Do you ever become part of that, the issue, do
 4 you get involved in an official capacity at
 5 some point?
 6 MS. JONES:
 7 A. No, the only thing on the fixation and I'm
 8 sure you'll go there, but that was a letter
 9 from the clinical chief at that point in time,
 10 right.
 11 CHAYTOR, Q.C.:
 12 Q. So up until that point in time when the issue
 13 of fixation is brought to your attention, up
 14 until then you had no official dealings with
 15 this issue?
 16 MS. JONES:
 17 A. No.
 18 CHAYTOR, Q.C.:
 19 Q. And the only information, I take it, you would
 20 have on the issue would have come from the
 21 executive management meetings?
 22 MS. JONES:
 23 A. And the board meetings.
 24 CHAYTOR, Q.C.:
 25 Q. And board meetings, okay.

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. When is it first brought up at the board?
 5 MS. JONES:
 6 A. When they would have been back in September,
 7 although we do know that the board chair and
 8 she's given evidence to that, that she would
 9 have been informed of the first, the latter
 10 part of September, it would have been an issue
 11 that was discussed, Dr. Williams and Mr.
 12 Tilley talked to the board about and did a
 13 presentation at that time.
 14 CHAYTOR, Q.C.:
 15 Q. Okay, and I'll ask you about that. So you
 16 know the board chair was advised -
 17 MS. JONES:
 18 A. Only now.
 19 CHAYTOR, Q.C.:
 20 Q. Only through this process.
 21 MS. JONES:
 22 A. Only through this process.
 23 CHAYTOR, Q.C.:
 24 Q. Mr. Tilley didn't tell you that at the time?
 25 MS. JONES:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. If we could have a look at P-0486, please,
 4 Registrar, and I believe it's page 17. This
 5 is a page from -
 6 MS. JONES:
 7 A. 29th of June.
 8 CHAYTOR, Q.C.:
 9 Q. Yes, from June 29th, 2005, executive team
 10 meeting in Placentia.
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. And if we go to the front page, we see that
 15 you are in attendance.
 16 MS. JONES:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. And it says after your name, "medicine,
 20 surgery and critical care", why would that be?
 21 MS. JONES:
 22 A. I'm thinking that Joyce Penney, who was the
 23 executive assistant who would have been taking
 24 these minutes, would have just couched it that
 25 way, rather than--because I don't see chief

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1 operating officer next to any of them, okay.
 2 CHAYTOR, Q.C.:
 3 Q. Okay.
 4 MS. JONES:
 5 A. And at that point in time we may not have
 6 called it adult acute care, right.
 7 THE COMMISSIONER:
 8 Q. I know I'm going to divert here, but I notice
 9 that on the current flow chart of the
 10 organization, there are chief operating
 11 officers and senior director and VPs?
 12 MS. JONES:
 13 A. Yes.
 14 THE COMMISSIONER:
 15 Q. What, if anything, is the difference in those
 16 titles?
 17 MS. JONES:
 18 A. The VPs which you have for corporate services
 19 people in information and medical services and
 20 diagnostics are regional portfolios, okay.
 21 The chief operating officers are geographic,
 22 for all intents and purposes, we have somebody
 23 who takes care of the full continuum of service
 24 in the peninsulas, Pat Coish-Snow; and then
 25 the Avalon area, so it's long-term care

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1 community as well as acute care. But inside
 2 of St. John's, because that portfolio was so
 3 large, there's no way that one chief operating
 4 officer could be responsible for community
 5 long-term care and supportive services, so
 6 what you have there is you have almost sector
 7 specific. I have all of acute care, Bev
 8 Clarke has all of the community services, then
 9 you have Pat Pilgrim who has mostly cancer
 10 care and your rehabilitation at the time. So
 11 because St. John's was so small, we couldn't
 12 do a linked programs across the continuum from
 13 community to acute care all the way to long-
 14 term care, which you could do in the
 15 geographic areas, like peninsulas and Avalon.
 16 So two very different--senior director for
 17 corporate research and planning, that is
 18 really a regional portfolio as well.
 19 THE COMMISSIONER:
 20 Q. Thank you.
 21 CHAYTOR, Q.C.:
 22 Q. Thank you, Commissioner. If we could go back
 23 then, this is the excerpt from the minutes of
 24 June 29th, 2005. And it indicates that 1.6
 25 follow-up from meeting with Department of

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1 Health and Community Service officials, June
 2 28th, 2005, "Louise Jones circulated draft
 3 notes from the 28th of June, 2005 meeting with
 4 the Department of Health and Community
 5 Services and agreed to refine these notes for
 6 in-depth discussion at next week's meeting."
 7 And there's no heading as such, no indication
 8 as to what the subject matter would have been.
 9 MS. JONES:
 10 A. Matter is, yeah.
 11 CHAYTOR, Q.C.:
 12 Q. Do you have any recollection as to what that
 13 meeting would have been about?
 14 MS. JONES:
 15 A. Not at this point in time, unless there is
 16 something else, an attachment for original
 17 draft notes.
 18 CHAYTOR, Q.C.:
 19 Q. And we don't have--is it normal when it's a
 20 meeting with the department not to indicate
 21 what the subject would be?
 22 MS. JONES:
 23 A. Unless this was one of those meetings where we
 24 were having ongoing discussions on a
 25 particular issue, people were obviously, I

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1 would think, that there were more than me,
 2 right, and we would have probably been, as an
 3 executive team meeting with the Department of
 4 Health and Community Services, so they would
 5 have been minutes or notes in this instance.
 6 CHAYTOR, Q.C.:
 7 Q. Did it have anything to do with the ER/PR
 8 issue?
 9 MS. JONES:
 10 A. No, would never have had anything to do with
 11 ER/PR.
 12 CHAYTOR, Q.C.:
 13 Q. Did you ever meet, other than after taking on
 14 your job as CEO, did you ever attend any of
 15 the meetings with the department on the ER/PR
 16 issue?
 17 MS. JONES:
 18 A. No.
 19 CHAYTOR, Q.C.:
 20 Q. And if we scroll down, this is June 28th, 2005
 21 and that's the only excerpts -
 22 MS. JONES:
 23 A. Yeah, okay.
 24 CHAYTOR, Q.C.:
 25 Q. There's nothing mentioned or certainly nothing

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1 recorded in this meeting in Placentia on the
 2 ER/PR issue?
 3 MS. JONES:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. So if it came up at that point in time, it
 7 wasn't part of the formal discussion at the
 8 meeting.
 9 MS. JONES:
 10 A. Wasn't part of the formal discussion, no.
 11 CHAYTOR, Q.C.:
 12 Q. And does the fact that you're in Placentia on
 13 that date with your colleagues, does that jog
 14 your memory as to whether or not that in fact
 15 was the time that you first learned about
 16 ER/PR?
 17 MS. JONES:
 18 A. No, it wouldn't jog my memory at all.
 19 CHAYTOR, Q.C.:
 20 Q. And we see that Dr. Williams was present in
 21 Placentia that day as well?
 22 MS. JONES:
 23 A. Uh-hm.
 24 CHAYTOR, Q.C.:
 25 Q. Okay, then page 18, we have minutes of the

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1 executive management committee meeting.
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Again this is exhibit 0486 and this meeting is
 6 held on July 5th, 2005.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And you are also in attendance at this
 11 meeting?
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. As is Dr. Williams.
 16 MS. JONES:
 17 A. Uh-hm.
 18 CHAYTOR, Q.C.:
 19 Q. And if we come to page 19, there's follow up
 20 from a meeting with the Department of Health
 21 and Community Service officials, June 28th,
 22 2005, "draft minutes from that meeting with
 23 the department officials were circulated and
 24 reviewed. Amendments are to be forwarded to
 25 Joyce Penney"?

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. "George Tilley will provide a copy of the
 5 updated minutes to the Department of Health
 6 and Community Services, per their request."
 7 MS. JONES:
 8 A. And, you know, it's hard to think three years
 9 back, but we did have regular meetings as
 10 executive teams with the department, so it
 11 could have been a meeting about issues that
 12 were going on, about planning that was going
 13 on at the department, it could have been
 14 anything. Without prompters as to what those
 15 notes were -
 16 CHAYTOR, Q.C.:
 17 Q. Yes, now the minutes probably still exist, the
 18 minutes from that.
 19 MS. JONES:
 20 A. From a meeting, yes.
 21 CHAYTOR, Q.C.:
 22 Q. From the draft meeting.
 23 MS. JONES:
 24 A. And usually what would happen if we had an
 25 executive team meeting with executive team,

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1 one time the department would take the minutes
 2 and the next time, the Eastern Health or the
 3 old Health Care Corporation would take
 4 minutes.
 5 CHAYTOR, Q.C.:
 6 Q. And I noticed in reviewing those executive
 7 management minutes, meeting minutes, that
 8 often though the issue is described as to what
 9 was discussed, the purpose for the meeting and
 10 what was -
 11 MS. JONES:
 12 A. And I would suggest, though, that there were a
 13 number of things and it could have been
 14 anything from pandemic planning to how we were
 15 setting ourselves up as an organization, so it
 16 could be an array of just general discussion.
 17 CHAYTOR, Q.C.:
 18 Q. So would there be any reason, though, not to
 19 have that listed in your minutes as to what
 20 was discussed?
 21 MS. JONES:
 22 A. It really, that Mrs. Penney would take the
 23 minutes and would reflect, you know, in this
 24 instance it was I was going to do the minutes,
 25 she probably wasn't even aware because she

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1 wouldn't have been at the, so we wouldn't have
 2 had any discussion, it might have been very
 3 generic like the minutes from last week,
 4 Louise is doing and you know, here they are
 5 now, send any changes.
 6 CHAYTOR, Q.C.:
 7 Q. So there's no significance when there's -
 8 MS. JONES:
 9 A. No.
 10 CHAYTOR, Q.C.:
 11 Q. No significance to any time when you see
 12 reference to a meeting without reference as to
 13 the issues discussed at the meeting, there's
 14 no significance to that?
 15 MS. JONES:
 16 A. No, no, and if there was a particular issue
 17 that we had with the department or there was
 18 something that was of concern to us, the issue
 19 would have been listed.
 20 CHAYTOR, Q.C.:
 21 Q. So to the best of your recollection, this is
 22 now July 5th, 2005.
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. This also did not pertain to the ER/PR issue.
 2 MS. JONES:
 3 A. No, no, and it would not have pertained to the
 4 ER/PR issue, I know that.
 5 CHAYTOR, Q.C.:
 6 Q. And this meeting, I believe is in St. John's?
 7 MS. JONES:
 8 A. Yes, it is.
 9 CHAYTOR, Q.C.:
 10 Q. And if we scroll down through this, there's
 11 relevant portions have been put there and I
 12 see no indication that, again, that the ER/PR
 13 issue came up?
 14 MS. JONES:
 15 A. No, that's right.
 16 CHAYTOR, Q.C.:
 17 Q. Have you looked through the executive
 18 management committee meetings in preparation
 19 for coming here today?
 20 MS. JONES:
 21 A. Just the latter ones, since July where I was.
 22 CHAYTOR, Q.C.:
 23 Q. So not the 2005 ones?
 24 MS. JONES:
 25 A. Not the 2005.

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1 CHAYTOR, Q.C.:

2 Q. So do you know when it first comes up in the

3 minutes? The issue of ER/PR?

4 MS. JONES:

5 A. The issue of ER/PR probably comes up in

6 September because we do have--I didn't do it,

7 but I have looked at them in the past and I've

8 also gone back to see if there was anything in

9 the Newfoundland and Labrador Health Boards

10 Association in terms of minutes and discussion

11 between CEOs, so I do believe the first

12 meeting in September, which would have been

13 after the Labour Day weekend and I would -

14 CHAYTOR, Q.C.:

15 Q. September 28th.

16 MS. JONES:

17 A. 28th, is it? And that is after the board

18 meeting.

19 CHAYTOR, Q.C.:

20 Q. Yes, after the board meeting. So tell me what

21 you recall then about the board meeting, your

22 recollection of the discussion around the

23 issue at that time?

24 MS. JONES:

25 A. It was, there was information that we were

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1 hearing at the board meeting that we hadn't

2 heard as an executive, so it really was an

3 information session for us. There was

4 discussion around the Ventana and the DAKO,

5 there's no question about that in my mind, and

6 there was also discussion that we have stopped

7 testing. We're referring out to Mount Sinai

8 and that we would have been in the process of

9 having or whether they were on the ground at

10 the time, but we had contracted with

11 individuals to come in to do external reviews

12 of the organization of that particular lab.

13 CHAYTOR, Q.C.:

14 Q. So then external reviewers had been contracted

15 with, to come in. Did you understand whether

16 or not they had already been in or were in the

17 process of -

18 MS. JONES:

19 A. I can't recall whether that would have, you

20 know, if you asked me to recall the meeting, I

21 wouldn't be able to recall that depth in the

22 meeting, right.

23 CHAYTOR, Q.C.:

24 Q. Was there any discussion then as to what the

25 reviewers may or may not have found?

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1 MS. JONES:

2 A. No.

3 CHAYTOR, Q.C.:

4 Q. Do you recall it being to that stage?

5 MS. JONES:

6 A. I wouldn't have thought it was to that stage

7 because it was the first time, so there was

8 really a listing of what ER/PR was, you know,

9 a little bit about ER/PR negative, a little

10 bit about treatment options and at the end of

11 the day--in terms of just giving some sense

12 and I thought as we were going through it,

13 because it was the first time, remember you

14 have a new board and it's the first time that

15 you have a major clinical issue and in the

16 past we probably would not have had that level

17 of discussion around a single issue, but where

18 we had stopped testing, okay, where there were

19 treatment options, where there maybe was

20 machine involvement and where we had peer

21 review, those were appropriate things to be

22 brought to the board, but we were hearing it

23 in its entirety.

24 CHAYTOR, Q.C.:

25 Q. And those are the things that stick out in

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1 your mind, that's what you remember?

2 MS. JONES:

3 A. Yes, yeah.

4 CHAYTOR, Q.C.:

5 Q. And the machine involvement, Ventana and DAKO,

6 that sticks out clearly in your mind?

7 MS. JONES:

8 A. Machine very clearly and we very clearly

9 talked about their being a manual process,

10 semi-automated, you know, to more of an

11 automated with a Ventana, so those

12 discussions, you know, now whether I'm

13 confusing that with stuff that we heard later

14 on, but it would have definitely been saying

15 with the new machine it would have been more

16 of an automated process than with the DAKO, so

17 that was something that was always talked

18 about.

19 CHAYTOR, Q.C.:

20 Q. But you recall that being said at the board

21 meeting when the board is first being informed

22 of the issue.

23 MS. JONES:

24 A. I would say that that was definitely there.

25 CHAYTOR, Q.C.:

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1 Q. And overall it was basically to explain what
 2 exactly ER/PR is, the clinical issue itself
 3 and the fact that this testing had stopped,
 4 now using Mount Sinai, that people are coming
 5 in, external reviewers have been in or are in
 6 the process of coming in.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And you recall this issue of the machinery.
 11 MS. JONES:
 12 A. And machinery.
 13 CHAYTOR, Q.C.:
 14 Q. Do you recall any other issue being discussed
 15 as to what could have caused the issue?
 16 MS. JONES:
 17 A. No, and those were the same kinds of
 18 discussions that happened for a long, long
 19 time, the machines, you know, the 40 steps -
 20 CHAYTOR, Q.C.:
 21 Q. But this is the first time you're hearing this
 22 kind of detail about it.
 23 MS. JONES:
 24 A. First time that we were hearing that kind of
 25 detail and we were hearing it at the board.

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1 CHAYTOR, Q.C.:
 2 Q. Okay, so you learned about the detail the same
 3 time that the board members -
 4 MS. JONES:
 5 A. As the board did, yes.
 6 CHAYTOR, Q.C.:
 7 Q. And that's what you recall having been
 8 discussed?
 9 MS. JONES:
 10 A. Absolutely.
 11 CHAYTOR, Q.C.:
 12 Q. And do you recall any other issue discussed as
 13 to what potentially could have been the cause
 14 of the problem?
 15 MS. JONES:
 16 A. No.
 17 CHAYTOR, Q.C.:
 18 Q. Do you recall any discussion around the issue
 19 of disclosure and how Eastern Health would go
 20 about the issue of disclosure?
 21 MS. JONES:
 22 A. I don't recall anything specific inside of
 23 those meetings, right.
 24 CHAYTOR, Q.C.:
 25 Q. And do you recall any particular questions

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1 from the board on the presentation given by
 2 Dr. Williams?
 3 MS. JONES:
 4 A. Not really because it was fairly detailed, so
 5 if there had been, it may have been for
 6 clarification of a particular point in, but I
 7 don't recall anything.
 8 CHAYTOR, Q.C.:
 9 Q. And did you, yourself, raise any issues or
 10 concerns?
 11 MS. JONES:
 12 A. We, as executive, relayed the CEO or whoever
 13 was presenting, presents to the board. Those
 14 discussions, if we had questions, would have
 15 come out inside of our own executive verses at
 16 the board.
 17 CHAYTOR, Q.C.:
 18 Q. So it would have been Mr. Tilley then, I take
 19 it and Mr. Williams who did this presentation?
 20 MS. JONES:
 21 A. Absolutely.
 22 CHAYTOR, Q.C.:
 23 Q. So you did not raise any questions or
 24 concerns? If you had them, you didn't raise
 25 them in that forum?

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1 MS. JONES:
 2 A. Inside the board, no.
 3 CHAYTOR, Q.C.:
 4 Q. Shortly thereafter, of course the issue became
 5 a public issue on October 2, 2005.
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. Were you brought into the loop more or the
 10 core group handling this issue at that point
 11 in time?
 12 MS. JONES:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. Were you provided copies of the media coverage
 16 around the event?
 17 MS. JONES:
 18 A. We always got copies of the media coverage,
 19 whatever was in the media on a weekly or even
 20 on a daily basis, depending on what it was,
 21 communications would send it out to executive.
 22 Communications also brought together on a
 23 regular basis items for the board.
 24 CHAYTOR, Q.C.:
 25 Q. So any issue regarding, any issue that's of a

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1 public nature regarding Eastern Health would
 2 be forwarded to all members of the executive?
 3 MS. JONES:
 4 A. Yes, as it was coming out, you know, you often
 5 see transcripts of, you know, whether it's
 6 "Open Line" or attachments from the "Evening
 7 Telegram" or whatever, so there would have
 8 been at a point in time, the day, the next day
 9 or whenever they were being put together.
 10 CHAYTOR, Q.C.:
 11 Q. So that can make for a lot of reading, some
 12 days.
 13 MS. JONES:
 14 A. A lot of scanning.
 15 CHAYTOR, Q.C.:
 16 Q. And do you read what comes across your desk or
 17 your computer in that regard?
 18 MS. JONES:
 19 A. Most people will tell you I read everything.
 20 CHAYTOR, Q.C.:
 21 Q. All right, and is that true of the ER/PR
 22 issue?
 23 MS. JONES:
 24 A. If it was in terms of the media coverage, I
 25 would have probably been reading at home. I

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1 certainly wouldn't have been, you know, the
 2 "Open Lines" or that, so other than scanning
 3 headlines and to see the nature of it,
 4 probably not every single word.
 5 CHAYTOR, Q.C.:
 6 Q. So do you recall then the story coming out in
 7 "The Independent" on October 2nd, 2005?
 8 MS. JONES:
 9 A. No, but we would have gotten that the
 10 following week as part of, you know, the media
 11 communications sending it to us, right, so I
 12 wouldn't normally have "The Independent", I
 13 don't purchase "The Independent".
 14 CHAYTOR, Q.C.:
 15 Q. So would that have been then, when you did see
 16 it and read it, would you have then talked to
 17 anybody about it? Did that become the subject
 18 for discussion amongst the executive or anyone
 19 else in your group?
 20 MS. JONES:
 21 A. I think that what you would have heard was
 22 that because we were dealing with individual
 23 clients as the ER/PR results were coming back,
 24 that at the end of the day there would have
 25 been some point in time when somebody would

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1 have talked to the media because we didn't
 2 have all of the results back. And that was
 3 really the impetus behind this particular
 4 story, it was an individual, I do believe, and
 5 that's how the story kind of got broken. So
 6 there was -
 7 CHAYTOR, Q.C.:
 8 Q. I'm sorry, just say that again?
 9 MS. JONES:
 10 A. The issue about ER/PR retesting, okay, we were
 11 talking--when the results of tests came back
 12 and we were dealing with clients on the
 13 results of tests, then that--we know, I think
 14 that at some point in time there would have
 15 been media interest in it, okay, but we would
 16 not have--if you go back to our disclosure
 17 policy that we had come from, in terms of the
 18 old Health Care Corporation, we would have
 19 always had the thought in our head that we
 20 wanted to deal individually with the client,
 21 rather than hearing it through the media.
 22 CHAYTOR, Q.C.:
 23 Q. What's your understanding of how this matter
 24 became a public issue?
 25 MS. JONES:

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1 A. In that particular October 2nd, "Independent"
 2 break of the story.
 3 CHAYTOR, Q.C.:
 4 Q. That a patient went to the media?
 5 MS. JONES:
 6 A. No, that it was uncovered?
 7 CHAYTOR, Q.C.:
 8 Q. I'm sorry? Uncovered through having given the
 9 results to a patient?
 10 MS. JONES:
 11 A. The story itself really talked about the
 12 ER/PR. So, how "The Independent" got the
 13 story, I don't know.
 14 CHAYTOR, Q.C.:
 15 Q. Okay, I thought you were saying that because
 16 it came out through -
 17 MS. JONES:
 18 A. No, no, how "The Independent" got the story, I
 19 wouldn't know how "The Independent" got the
 20 story, but that was -
 21 CHAYTOR, Q.C.:
 22 Q. Okay.
 23 MS. JONES:
 24 A. And we would have only--we would not have gone
 25 public with anything around ER/PR because we

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1 always had this issue of wanting to let
 2 patients know first -
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 MS. JONES:
 6 A. - before we would let public. And at the end
 7 of the day, we had already stopped testing.
 8 CHAYTOR, Q.C.:
 9 Q. Right, okay. So whether or not there were any
 10 discussions between the reporter and the
 11 Communications Department of Eastern Health,
 12 you don't know that?
 13 MS. JONES:
 14 A. I have no idea.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. If we could go then to 0486 and I
 17 believe it's page 39. And this is the
 18 Executive Management meeting of September 28,
 19 2005. And Ms. Jones, I believe this is the
 20 first time it appears official in your
 21 official minutes of your meetings.
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And we're on page 39?

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. We'll just go back here and we see that you
 5 are in attendance.
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. And Dr. Williams is in attendance. And I take
 10 it, Mr. Tilley would have been chairing the
 11 meeting?
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. And under 2.1 "Laboratory ER/PR Update". Now,
 16 it says "update" which would lead you to
 17 believe that it must have been discussed at an
 18 earlier time because you're being provided
 19 with an update?
 20 MS. JONES:
 21 A. I'm not sure whether that's a correct
 22 interpretation of that. Update being an
 23 update from Dr. Williams, but I'm, you know,
 24 have to almost ask Joyce Penney where that
 25 came from.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. And your review, as well, of the
 3 minutes though, this appeared to be the first
 4 time it was discussed.
 5 MS. JONES:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And it was after the board meeting?
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. So, perhaps it's an update from the past
 13 couple of days?
 14 MS. JONES:
 15 A. Yeah.
 16 CHAYTOR, Q.C.:
 17 Q. "Additional information has been received from
 18 Mount Sinai related to the ER/PR concerns in
 19 the laboratory. Dr. Williams advised that a
 20 meeting will be scheduled with the
 21 pathologists, oncologist and laboratory staff
 22 to review the new information and make
 23 recommendations. Consultants from Mount
 24 Sinai, chief technologists and chief
 25 pathologists have completed their site visit.

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1 Specimens have not yet been received from
 2 central, west and Corner Brook. However, they
 3 should be received by the end of next week.
 4 Once received, these specimens will be sent
 5 out of province for testing. Consideration is
 6 being given to retesting specimens for the
 7 period 1997 through 1998. We are positioned
 8 to move with a communications strategy when
 9 required". And "communications strategy" is
 10 in bold. So, do you have any other
 11 independent recollection of what would have
 12 been discussed at that meeting?
 13 MS. JONES:
 14 A. No, because we would have had a discussion or
 15 it would have been brought to board. So, we
 16 would have been aware of what was at board.
 17 And this then becomes bringing it into the
 18 executive minutes.
 19 CHAYTOR, Q.C.:
 20 Q. And what do you recall being the additional
 21 information having been received from Mount
 22 Sinai related to the concerns? Do you recall
 23 what that was?
 24 MS. JONES:
 25 A. He may never have said what that is. And Dr.

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1 Williams was meeting here with the
 2 pathologists, oncologists and laboratory staff
 3 and remember, this is still a laboratory issue
 4 -
 5 CHAYTOR, Q.C.:
 6 Q. Yes.
 7 MS. JONES:
 8 A. - that he would have been following through on
 9 whatever he needed to follow through on.
 10 CHAYTOR, Q.C.:
 11 Q. And it's to review the new information and
 12 make recommendations.
 13 MS. JONES:
 14 A. Uh-hm.
 15 CHAYTOR, Q.C.:
 16 Q. And then it goes on to say, "consultants from
 17 Mount Sinai, chief technologists and chief
 18 pathologist have completed their site visit".
 19 MS. JONES:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. Now, the chief pathologist, we understand, was
 23 from B.C. -
 24 MS. JONES:
 25 A. Was Banerjee.

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1 CHAYTOR, Q.C.:
 2 Q. - Cancer Institute.
 3 MS. JONES:
 4 A. Yeah.
 5 CHAYTOR, Q.C.:
 6 Q. And so "meeting with the staff to review the
 7 new information, make recommendations", you
 8 don't have any recollection as to what that
 9 was about.
 10 MS. JONES:
 11 A. No, and any time you have a review of that and
 12 it doesn't matter what kind of review, you
 13 usually meet with the consultants before they
 14 leave, before they actually get the reports.
 15 So, some of this may very well have been
 16 follow up on the discussion that they had
 17 before they left. And that's only an
 18 assumption on my part.
 19 CHAYTOR, Q.C.:
 20 Q. Okay. And this is the end of September, 2005.
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And the specimens had not yet been received
 25 from central, west and Corner Brook.

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1 MS. JONES:
 2 A. Yeah.
 3 CHAYTOR, Q.C.:
 4 Q. And then they would be sent out of province.
 5 What is this about consideration being given
 6 to the retesting specimens for the period 1997
 7 to 1998?
 8 MS. JONES:
 9 A. I can't recall what that would have been
 10 inside that meeting, but I do know that we did
 11 go back to '97 after. So, it may very well
 12 have been on this issue of what was the window
 13 and -
 14 CHAYTOR, Q.C.:
 15 Q. So, at this point in time there hadn't been
 16 consideration to go back '97 -
 17 MS. JONES:
 18 A. That's what it appears in September of this
 19 year.
 20 CHAYTOR, Q.C.:
 21 Q. That it had started with 1999?
 22 MS. JONES:
 23 A. Yeah.
 24 CHAYTOR, Q.C.:
 25 Q. Or 1998?

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1 MS. JONES:
 2 A. 1998, yeah.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. "And we are positioned to move with a
 5 communications strategy when required". What
 6 discussion do you recall about that and what
 7 was the communication strategy?
 8 MS. JONES:
 9 A. Wouldn't have had that discussion inside of
 10 executive, just if, in fact, there was
 11 anything that needed to be done, that they had
 12 been working with communication. We didn't
 13 talk a lot about individual communication
 14 strategies at executive. And if, in fact,
 15 there was any real discussion, it may have
 16 been, we suggest, you know, we move in A, B or
 17 add this to it.
 18 CHAYTOR, Q.C.:
 19 Q. So, executive is being told that there is a
 20 communication strategy, however, in place.
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And they're in a position to move forward if -
 25 MS. JONES:

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1 A. If they need.
 2 CHAYTOR, Q.C.:
 3 Q. - required. Do you understand--what was meant
 4 by if required or when required, sorry?
 5 MS. JONES:
 6 A. Well, I would think that at this particular
 7 point in time because we--and I think I just
 8 said it earlier, as we are dealing with
 9 individual clients, at some point in time, it
 10 may break public.
 11 CHAYTOR, Q.C.:
 12 Q. So, a communication strategy, though when
 13 required, would be dealing with the issue on a
 14 public basis.
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. Because you have your policy on disclosure -
 19 MS. JONES:
 20 A. On disclosure and we know exactly what we're
 21 going to do with that when we have the
 22 information, individual clients will be
 23 disclosed.
 24 CHAYTOR, Q.C.:
 25 Q. So this would have to do with the disclosure

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1 or communication to the greater community.
 2 MS. JONES:
 3 A. That's right, would have been public.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. In answering my question on the 1997 to
 6 1998 period, you indicated that they may have
 7 gone back or thought about a window of
 8 opportunity, what do you mean by that?
 9 MS. JONES:
 10 A. Well, the discussion--what I know now and I'm
 11 sure that we had stopped testing and then we
 12 were pulling slides, there was a window of
 13 opportunity where Tamoxifen may be of benefit.
 14 And so that's what they were really looking
 15 at. We also have, I think, Dako coming in at
 16 97 or 98. Which is a change in the way that
 17 we did immunohistochemistry testing.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, from the bioassay -
 20 MS. JONES:
 21 A. From the bioassay to the immunohistochemistry.
 22 CHAYTOR, Q.C.:
 23 Q. But was there some consideration that an
 24 afterthought that maybe we could go back

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1 another year, do you recall that? Like, why
 2 wasn't the window of opportunity of extended?
 3 MS. JONES:
 4 A. No, this would have been Bob saying, we've
 5 done this and we are thinking about,
 6 obviously, do we go back to probably, in this
 7 instance, moving from the bioassay to the
 8 immunohistochemistry, but is that the actual
 9 recall, I have no idea.
 10 THE COMMISSIONER:
 11 Q. Ms. Jones, just so that I get a feel for how
 12 these meetings work, is this a place for a
 13 person like Dr. Williams who has a particular
 14 position to inform the rest of the executive.
 15 MS. JONES:
 16 A. Yes.
 17 THE COMMISSIONER:
 18 Q. Or is this a place where Dr. Williams says,
 19 what do you think about this or would you feel
 20 free, for example, if you were getting a
 21 report or an update from another member of the
 22 executive team and either you felt that, you
 23 know, you had information which might be
 24 beneficial to pass it along in that context,
 25 or if you thought, that's not such a hot move,

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1 would you, in that context, say what your
 2 opinion was?
 3 MS. JONES:
 4 A. The most times it was really for information,
 5 okay. As we evolved in Eastern Health, we did
 6 bring forward briefs on particular issues
 7 where we wanted decisions made.
 8 THE COMMISSIONER:
 9 Q. Uh-hm.
 10 CHAYTOR, Q.C.:
 11 Q. We wanted input. If there was a complicated
 12 issue that crossed more than one portfolio, we
 13 would come and have open discussion around it,
 14 how we were going to move forward with a
 15 particular issue; how were going to structure
 16 a particular issue. So, many times, executive
 17 is for information, but we had a process,
 18 although not always articulated, whereas we
 19 would bring a briefing note where we were
 20 looking for a decision from executive on a
 21 particular issue, that would have implications
 22 for more than just a particular area. So, -
 23 THE COMMISSIONER:
 24 Q. But the call would be on the person bringing
 25 the information, would it?

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1 MS. JONES:
 2 A. And, yes, and most of the areas that you talk
 3 about, like human resources or even
 4 information technology or laboratory or
 5 whatever, it would have been the executive
 6 that they had responsibility for that area
 7 because I wouldn't be able to make any comment
 8 on laboratory. I might have, you know,
 9 responded to what was said, but not because I
 10 had any in-depth knowledge about that. But
 11 if, in fact, we were talking about nursing
 12 practice across the entire Eastern Health,
 13 because of my background in knowledge, I might
 14 have been able to contribute to a particular
 15 decision or an issue that might have been
 16 brought to the table.
 17 THE COMMISSIONER:
 18 Q. All right. Thank you.
 19 CHAYTOR, Q.C.:
 20 Q. Thank you, Commissioner. Ms. Jones, then as
 21 of this date, September 28, 2005, who do you
 22 understand is in charge of the issue?
 23 MS. JONES:
 24 A. On the lab part, it is still Dr. Williams.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And what about the part dealing with
 2 the communication strategy that's referenced
 3 in the minutes?
 4 MS. JONES:
 5 A. He would have been working with communications
 6 on developing that strategy and how much
 7 involvement anybody else had with that. I
 8 can't speak to it.
 9 CHAYTOR, Q.C.:
 10 Q. And overall though, the person who would be in
 11 charge of managing that issue would be who?
 12 MS. JONES:
 13 A. In terms of what issue?
 14 CHAYTOR, Q.C.:
 15 Q. Managing the communications aspect of the
 16 issue.
 17 MS. JONES:
 18 A. Direction would have been taken from whether--
 19 Bob or George Tilley in that instance because
 20 a communications strategy would have been a
 21 strategy that would have been developed by
 22 communications and it would have had to be
 23 approved by somebody to move forward with it.
 24 CHAYTOR, Q.C.:
 25 Q. And at this point in time, who's reporting on

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1 being in a position to move with a
 2 communications strategy? Is all part of Dr.
 3 Williams' presentation to the executive or is
 4 Mr. Tilley also making that assertion?
 5 MS. JONES:
 6 A. I can't tell you that far back.
 7 CHAYTOR, Q.C.:
 8 Q. So your recollection though, as to who was
 9 managing the issue from the clinical aspect,
 10 was clearly Dr. Williams?
 11 MS. JONES:
 12 A. Dr. Williams, that's right.
 13 CHAYTOR, Q.C.:
 14 Q. And in terms of the communication surrounding
 15 the issue -
 16 MS. JONES:
 17 A. I would have thought that there would have
 18 been a number of individuals which would have
 19 probably included Mr. Tilley at that time, as
 20 well as Bob, and I'm not even sure that maybe
 21 Mr. Steve Dodge might have been involved in
 22 some of the discussion because communication
 23 reported through that portfolio to Mr. Dodge.
 24 CHAYTOR, Q.C.:
 25 Q. And is that your recollection in dealing with

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1 the issue, that Mr. Dodge had much, if any,
 2 involvement?
 3 MS. JONES:
 4 A. I wouldn't have known that personally.
 5 CHAYTOR, Q.C.:
 6 Q. Did he ever speak to the issue at an executive
 7 management meeting?
 8 MS. JONES:
 9 A. Well, at executive management, you will notice
 10 that Ms. Bonnell was part of the executive
 11 management, so Ms. Bonnell would have probably
 12 been bringing forward, if in fact it came--
 13 sorry, if in fact it came to that, to talk to
 14 the components of a program. So you see -
 15 CHAYTOR, Q.C.:
 16 Q. And I notice that she's -
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. - she's at this particular meeting, as is Mr.
 21 Dodge.
 22 MS. JONES:
 23 A. Dodge, that's right.
 24 CHAYTOR, Q.C.:
 25 Q. And what's your recollection as to who would

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1 speak, if necessary, to issues regarding
 2 communications around this issue?
 3 MS. JONES:
 4 A. Susan would have done the technical pieces of
 5 it and where we were going or what her advice
 6 would have been.
 7 CHAYTOR, Q.C.:
 8 Q. And she formally -
 9 MS. JONES:
 10 A. And this one here though says that we're
 11 positioned to move with a communication
 12 strategy, so we probably would never have even
 13 had that discussion there.
 14 CHAYTOR, Q.C.:
 15 Q. So I'm just wondering who would be speaking to
 16 the issue, and in any event, Ms. Bonnell would
 17 be reporting to Mr. Dodge.
 18 MS. JONES:
 19 A. That's right.
 20 CHAYTOR, Q.C.:
 21 Q. And/or Mr. Tilley?
 22 MS. JONES:
 23 A. That's--no, she reported to Mr. Dodge.
 24 CHAYTOR, Q.C.:
 25 Q. On this issue, do you know that?

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1 MS. JONES:
 2 A. I don't know that, but in terms of
 3 organizational structure, she would have
 4 reported to Mr. Dodge, but I would say to you,
 5 in terms of even in my portfolio now, there
 6 are many times that you would talk directly to
 7 the communication person, not always through
 8 the vice-president on particular issues.
 9 CHAYTOR, Q.C.:
 10 Q. And what's your overall sense in having sat in
 11 on those meetings as to whether or not Mr.
 12 Dodge appeared to be involved or in charge of
 13 the communications around the issue?
 14 MS. JONES:
 15 A. I can't respond to that like in September.
 16 CHAYTOR, Q.C.:
 17 Q. So you have no recollection one way or the
 18 other?
 19 MS. JONES:
 20 A. No.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. When did you then personally have any
 23 involvement in this issue?
 24 MS. JONES:
 25 A. I don't believe I would have said I would have

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1 had any involvement in this issue until I took
 2 on the role that I'm in now. To say that I
 3 knew about the issue as it was evolving in
 4 terms of the media, as well as where we were
 5 with respect to reports being back and
 6 recommendations being implemented, that was
 7 more of a generic for information only, in
 8 terms of executive. But in terms of directing
 9 anything, not really, and then the only issue
 10 that would have been referred to me in a
 11 secondary fashion -
 12 CHAYTOR, Q.C.:
 13 Q. That's in your official capacity.
 14 MS. JONES:
 15 A. I don't--only in July of this year.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, and what about in your--you mentioned
 18 earlier in answering some of my questions, the
 19 issue of fixation.
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. That came to your attention in your official
 24 capacity as COO at the time?
 25 MS. JONES:

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1 A. That's right, as a copy on a letter.
 2 CHAYTOR, Q.C.:
 3 Q. Yes.
 4 MS. JONES:
 5 A. And I would have had discussion with the
 6 program director on that issue.
 7 CHAYTOR, Q.C.:
 8 Q. Okay. If we could look, please, at P-0729?
 9 THE COMMISSIONER:
 10 Q. P-0729 should be in your book.
 11 MS. JONES:
 12 A. Yes.
 13 THE COMMISSIONER:
 14 Q. If you'd prefer to -
 15 MS. JONES:
 16 A. I have my own book.
 17 THE COMMISSIONER:
 18 Q. All right, okay.
 19 MS. JONES:
 20 A. With all my notes in them.
 21 CHAYTOR, Q.C.:
 22 Q. Hope it helps. So 0729, now this is a letter.
 23 Sorry, it's an email.
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. From Denise Dunn to yourself, Maria Tracey and

3 Dianne Clements.

4 MS. JONES:

5 A. That's right.

6 CHAYTOR, Q.C.:

7 Q. And it's dated September 29th, 2005.

8 MS. JONES:

9 A. Yeah.

10 CHAYTOR, Q.C.:

11 Q. And it's "Louise, Maria, can the surgery and

12 peri-operative program readers review, please.

13 Thanks, Bob."

14 MS. JONES:

15 A. Yeah.

16 CHAYTOR, Q.C.:

17 Q. So Denise Dunn was who?

18 MS. JONES:

19 A. Is Dr. Williams' secretary.

20 CHAYTOR, Q.C.:

21 Q. So she's sending this obviously on behalf of

22 Bob, being Bob Williams?

23 MS. JONES:

24 A. That's right.

25 CHAYTOR, Q.C.:

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1 Q. And this is going to yourself. Who's Maria

2 Tracey?

3 MS. JONES:

4 A. Maria Tracey is the program director for peri-

5 operative, which runs -

6 CHAYTOR, Q.C.:

7 Q. And who is Dianne Clements?

8 MS. JONES:

9 A. Dianne Clements was my secretary.

10 CHAYTOR, Q.C.:

11 Q. Okay, and in brackets, they're sending Dr.

12 Felix's and Dr. Kwan's copies by fax.

13 MS. JONES:

14 A. That's right.

15 CHAYTOR, Q.C.:

16 Q. Okay. So this is--and if we look at what the

17 attachment is on page two, it's a letter of

18 September 26th, 2005, Dr. Williams from Dr.

19 Cook.

20 MS. JONES:

21 A. Yes.

22 CHAYTOR, Q.C.:

23 Q. Okay, and this is September 26th 2005, so it's

24 two days before the executive management

25 minutes that we just looked at.

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1 MS. JONES:

2 A. Yes.

3 CHAYTOR, Q.C.:

4 Q. September 28th, 2005, and the issue that's

5 dealt with in here is an issue regarding

6 tissue preservation at the OR level.

7 MS. JONES:

8 A. Yes.

9 CHAYTOR, Q.C.:

10 Q. Do you recall Dr. Williams, on September 28th,

11 was this issue addressed or brought up at the

12 executive management?

13 MS. JONES:

14 A. I can't recall whether it was or not.

15 CHAYTOR, Q.C.:

16 Q. Do you think you would recall, given that it

17 involves the OR?

18 MS. JONES:

19 A. No, because at that time, we wouldn't have

20 been having that sense of, you know, fixation.

21 Just using the word "fixation" wouldn't have

22 not--wouldn't have kind of triggered anything

23 at that point.

24 CHAYTOR, Q.C.:

25 Q. So the first time you heard of this issue,

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1 it's not reflected in the minutes of September

2 28th that there was any discussion around

3 this.

4 MS. JONES:

5 A. No.

6 CHAYTOR, Q.C.:

7 Q. I'm just wondering then, you were sent this by

8 email copy on September 29th, the day after

9 your meeting.

10 MS. JONES:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. So would this have been the first time this

14 issue was brought to your attention?

15 MS. JONES:

16 A. Yes, it would have been.

17 CHAYTOR, Q.C.:

18 Q. Okay. So you don't recall it having been

19 brought up in the -

20 MS. JONES:

21 A. No, and actually, I have no idea when the exit

22 interviews were with the consultants. Dr.

23 Cook references this as being brought up at

24 that point in time.

25 CHAYTOR, Q.C.:

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1 Q. So they were done presumably sometime before
 2 September 26th when Dr. Cook was able to write
 3 this letter?
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and if we see the handwriting up in the
 8 corner, there's handwritten notes, it looks
 9 like to Louise Jones, Maria Tracey, Dr. Al
 10 Felix, Dr. Allan Kwan.
 11 MS. JONES:
 12 A. Yeah.
 13 CHAYTOR, Q.C.:
 14 Q. And I don't know if you can read the rest.
 15 MS. JONES:
 16 A. Surgery peri-operative, yeah, for review,
 17 which is what Denise would have sent to us.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, and why would you be receiving this
 20 letter or a copy of it?
 21 MS. JONES:
 22 A. I would expect that Dr. Williams would want to
 23 make sure that I had followed up on it,
 24 because it is written to--from Dr. Cook to Dr.
 25 Williams. I would--and I would have recalled

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1 saying to--calling and saying to Maria,
 2 "there's a letter there, deal with it."
 3 CHAYTOR, Q.C.:
 4 Q. Yes, and I'll ask you about what you did. I'm
 5 just wondering why you would be getting it.
 6 So I take it it's because you are responsible
 7 for the peri-operative program?
 8 MS. JONES:
 9 A. Yes, absolutely.
 10 CHAYTOR, Q.C.:
 11 Q. And surgery?
 12 MS. JONES:
 13 A. Yeah, and this was something that needed to
 14 happen in this program.
 15 CHAYTOR, Q.C.:
 16 Q. Okay. If we just look at the content then of
 17 the letter, it says "following the exit
 18 interviews of both the medical and technical
 19 consultants," so that would be the external
 20 reviewers?
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. "One of the issues identified in
 25 immunohistochemical staining of estrogen and

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1 progesterone receptors concerns adequate
 2 fixation of the specimen. It appears in some
 3 cases that mastectomy specimens and other
 4 breast biopsies could very well be left lying
 5 overnight or over the weekend in the OR
 6 without adequate formalin fixation."
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. "I would strongly recommend," and again, this
 11 is Dr. Cook, "I would strongly recommend that
 12 all mastectomies, needle localizations and
 13 lumpectomies with axillary node dissection
 14 should be booked first thing in the morning in
 15 the OR from Monday to Friday. Ideally, these
 16 procedures should not be performed on Friday
 17 afternoons. Every effort should be made to
 18 ensure that the cases are forwarded to the lab
 19 in a timely fashion," I take it he means. "I
 20 would appreciate it if this information could
 21 be forwarded to those individuals responsible
 22 for the OR booking. Sincerely yours, Donald
 23 M. Cook."
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:
 2 Q. Ms. Jones, prior to receiving a copy of this
 3 letter, were you aware that this could have
 4 been happening, that specimens could be left
 5 lying overnight or over the weekend without
 6 adequate formalin fixation? Were you aware of
 7 this?
 8 MS. JONES:
 9 A. Not personally, but it wouldn't surprise me.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and why is that? Why wouldn't that
 12 surprise you?
 13 MS. JONES:
 14 A. Because I had worked in a case room where we
 15 had, you know, placentas that would have been
 16 left after a period of time, and been moved to
 17 the pathology lab or whatever the next day or
 18 sometime over a weekend.
 19 CHAYTOR, Q.C.:
 20 Q. Yes, but placentas wouldn't be--any testing on
 21 the placentas wouldn't have anything to do
 22 with -
 23 MS. JONES:
 24 A. Yes, there is testing on placentas.
 25 CHAYTOR, Q.C.:

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1 Q. Yes, but it wouldn't have anything to do with
 2 the health of the patient. So in terms of any
 3 testing on breast tissue, does it surprise you
 4 that that would be left overnight or over the
 5 weekends without adequate formalin?
 6 MS. JONES:
 7 A. Not knowing the actual--I would know that at
 8 the end of the day, there would be rounds to
 9 pick up, right. So you know, if there were
 10 cases after hours, okay, into the evening,
 11 into the weekend, may very well be, but there
 12 would be normal transport to the lab
 13 throughout the entire seven days of the week.
 14 So, you know, whether in fact this actually
 15 happened, I wouldn't be able to say
 16 absolutely, and how many specimens or
 17 whatever, Maria Tracey and the division
 18 managers would be able to speak specifically
 19 to that.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. Well then, what did you do when you
 22 read this to try and determine the voracity of
 23 it?
 24 MS. JONES:
 25 A. Well, first, my first reaction when I read

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1 this is what Dr. Don Cook is asking can't be
 2 done, okay, and the can't be done was having
 3 all mastectomies, needle localizations and
 4 lumpectomies being done early in the day,
 5 because if you know anything about operating
 6 room and the flow of operating room, you
 7 usually do your large cases in the morning,
 8 followed by your smaller cases in the
 9 afternoon. So really, we could not have that
 10 kind of work flow, if in fact we were to do
 11 the work that needed to be done, from an
 12 operating room procedure. So my discussion
 13 with Maria Tracey was, okay, we know, I know,
 14 you know that all of those particular
 15 specimens can't be done early in the morning,
 16 okay. That you need to meet with Dr. Cook to
 17 find out what alternatives are there to be
 18 able to deal with their issue of fixation, and
 19 I do know that those meetings did occur and
 20 that, in fact, yes, mastectomies, needle
 21 localizations and that happened in the normal
 22 flow, but there's a process of, you know,
 23 picking up the specimens and then, you know,
 24 the person on call, if it's after hours and
 25 those kinds of things. So I do know that they

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1 worked their way through it, but they didn't
 2 work their way through it the way Dr. Cook
 3 wanted it to be worked through, but they did
 4 work their way through it in a satisfactory
 5 fashion that will allow them to get their
 6 specimens in the time frame that they needed
 7 to receive them.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. So when you received this letter, your
 10 concern, what you noticed right away was that
 11 what Dr. Cook was asking for, in terms of
 12 scheduling of the procedure, couldn't happen?
 13 MS. JONES:
 14 A. Yeah. But there had to be some other way of
 15 meeting what he needed and they needed to
 16 discuss it out.
 17 CHAYTOR, Q.C.:
 18 Q. And the issue, in terms of the specimens and,
 19 I don't know, maybe it's equally important for
 20 placentas, I don't know, but I'm just thinking
 21 the idea that specimens wouldn't be in
 22 adequate formalin, did that cause you any
 23 concern and did you make any investigation or
 24 question around that?
 25 MS. JONES:

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1 A. Well, Mrs. Tracey would have looked at that
 2 and I do know that they did discuss the size
 3 of the containers that they were in and you
 4 know, the percentage of formalin and those
 5 kinds of things. What I would say to you is
 6 that there is nobody in the pathology lab 365
 7 days of the year, 24 hours a day. So there are
 8 obviously specimens, and it doesn't matter,
 9 coming to the lab at times other than when
 10 personnel are there. So this obviously was a
 11 cue to say we need a certain fixation and we
 12 need a certain formalin or size of bucket or
 13 whatever. I do know though that over the
 14 years, if there are issues with specimens,
 15 then they're dealt with on an individual
 16 basis, because the lab receives a specimen
 17 that it's not appropriate or is--you know, the
 18 container leaks or whatever. So those are
 19 dealt with on an individual basis, but we had
 20 not heard this from the lab in the past.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. So this hadn't been brought--when I
 23 asked you initially whether you were aware of
 24 this before, you said not personally.
 25 MS. JONES:

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1 A. No.
 2 CHAYTOR, Q.C.:
 3 Q. But had this been brought to anybody's
 4 attention?
 5 MS. JONES:
 6 A. The individual issue of a specimen maybe not
 7 being fixed in the way may very well have been
 8 brought through, but it would be division
 9 manager, not necessarily Maria Tracey, who
 10 would know that.
 11 CHAYTOR, Q.C.:
 12 Q. And have you heard that? Have you heard that
 13 -
 14 MS. JONES:
 15 A. No, I have not heard it.
 16 CHAYTOR, Q.C.:
 17 Q. - there were issues brought to the divisional
 18 manager regarding fixation of specimens prior
 19 to this?
 20 MS. JONES:
 21 A. No.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. Would there not be--and I understand
 24 that you're saying that it would be up to the
 25 lab to indicate if there's an issue -

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. - regarding the size of the bucket, the amount
 5 of formalin or whatever, would there not be
 6 protocols in place though in the OR as to
 7 preservation of tissue?
 8 MS. JONES:
 9 A. There would have been--the operating room
 10 responsibility is to secure--take the tissue,
 11 whether it be the mastectomy, it doesn't
 12 matter, we're talking breast here, or the
 13 biopsy, and to put it in a solution that was
 14 actually identified or there would be some
 15 tissue that you would not be putting in
 16 formalin because it had to be processed in a
 17 different way. So they would have had
 18 direction on which needs to go into formalin,
 19 which doesn't need to go into formalin, and
 20 those directions would come from the lab
 21 themselves, right. That is not an area of
 22 expertise that nursing would have. They would
 23 take direction based upon what it is that the
 24 receiving department would actually need in
 25 terms of the processing for their specimens.

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1 CHAYTOR, Q.C.:
 2 Q. Are you taught, as part of your nursing
 3 training, the importance of tissue
 4 preservation?
 5 MS. JONES:
 6 A. My training goes back 30 odd years and I don't
 7 remember that.
 8 CHAYTOR, Q.C.:
 9 Q. Do you know whether or not it's part of the
 10 training now?
 11 MS. JONES:
 12 A. I would say that it probably isn't part of the
 13 training, but in terms of your orientation to
 14 a particular work area, in terms of specimens,
 15 bottles, formalin, all of those kinds of
 16 things, that's part of the on-the-job
 17 training.
 18 CHAYTOR, Q.C.:
 19 Q. You would expect nurses working in the OR
 20 would be familiar -
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. - with the importance of tissue preservation?
 25 MS. JONES:

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1 A. Absolutely, because that is part of the job
 2 that they do.
 3 CHAYTOR, Q.C.:
 4 Q. Yes.
 5 THE COMMISSIONER:
 6 Q. That is the job of the nurse though, is it?
 7 MS. JONES:
 8 A. The nurse would take the specimen and put it
 9 in a container, and she would need to know how
 10 much or the formalin content or some specimens
 11 go dry. They do not--are not put in any kind
 12 of a fixative.
 13 THE COMMISSIONER:
 14 Q. But the responsibility for dealing with tissue
 15 that is removed in the OR is that of a nurse,
 16 not somebody else in the OR?
 17 MS. JONES:
 18 A. It is of a nurse.
 19 THE COMMISSIONER:
 20 Q. All right, thank you.
 21 CHAYTOR, Q.C.:
 22 Q. And who gives that direction to the nurse?
 23 How does the nurse know how much formalin and
 24 the appropriate formalin?
 25 MS. JONES:

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1 A. Well, that wouldn't be coming from anywhere in
 2 nursing policy. It would come from a lab
 3 perspective as to what--does it need to be
 4 covered, totally covered, you know, formalin,
 5 how much, how big, those kinds of things.
 6 CHAYTOR, Q.C.:
 7 Q. And we know that there is or there's certainly
 8 a draft new policy to deal with this issue.
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. Do you know was there any policy or protocol
 13 standard of practice in place prior to the new
 14 one that we've seen drafted?
 15 MS. JONES:
 16 A. That's best answered by Mrs. Tracey or the
 17 division managers. I don't know personally at
 18 the time.
 19 CHAYTOR, Q.C.:
 20 Q. So whether or not there was, you're not able
 21 to speak to that?
 22 MS. JONES:
 23 A. No, I would speak to the fact that we would
 24 have had a practice. We would have been using
 25 it for years and years and years, and that if

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1 there were issues with the way a specimen was
 2 received, and it doesn't matter whether it's a
 3 specimen in formalin or any other specimen
 4 that we would send to the lab, that the lab
 5 dealt with it individually with either the
 6 user or the manager.
 7 CHAYTOR, Q.C.:
 8 Q. And in terms of you were aware that specimens
 9 could be left for a long period of time,
 10 overnight or over the weekend?
 11 MS. JONES:
 12 A. Well, certainly overnight.
 13 CHAYTOR, Q.C.:
 14 Q. Right, in your own clinical practice. Would
 15 that have been without adequate formalin as
 16 well?
 17 MS. JONES:
 18 A. They would have all been put in formalin then.
 19 There is--you know, depending on where you
 20 worked, it would have been a certain size
 21 bucket that would have whatever, right.
 22 CHAYTOR, Q.C.:
 23 Q. So the issue of the specimen being left
 24 without adequate formalin, were you surprised
 25 by that?

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1 MS. JONES:
 2 A. I don't see that really here. It's breast
 3 biopsies could well be left lying overnight or
 4 -
 5 CHAYTOR, Q.C.:
 6 Q. Or over the weekend in the OR without adequate
 7 formalin fixation.
 8 MS. JONES:
 9 A. Yeah, and that's -
 10 CHAYTOR, Q.C.:
 11 Q. So that's what I'm referring to.
 12 MS. JONES:
 13 A. Yes. I can't really comment any more on that,
 14 except to know that if there was inadequate
 15 fixation or formalin, then that would have
 16 been brought to the attention on the
 17 individual specimen.
 18 CHAYTOR, Q.C.:
 19 Q. But it didn't particularly jump off the page
 20 to you that it was without adequate formalin
 21 fixation?
 22 MS. JONES:
 23 A. No.
 24 CHAYTOR, Q.C.:
 25 Q. And at the time you read this?

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1 MS. JONES:
 2 A. No.
 3 CHAYTOR, Q.C.:
 4 Q. And did you speak to anyone about that to find
 5 out -
 6 MS. JONES:
 7 A. Well, that was what I would have spoke to
 8 Maria about, right.
 9 CHAYTOR, Q.C.:
 10 Q. So you would have asked her whether or not
 11 that was the case, that they had left
 12 specimens without -
 13 MS. JONES:
 14 A. Had they had any issues that the lab had
 15 brought forward to their attention.
 16 CHAYTOR, Q.C.:
 17 Q. And what--but did she--okay, that's one issue,
 18 whether or not the lab brought it to their
 19 attention, and you said that she said no to
 20 that, it hadn't been brought to their
 21 attention?
 22 MS. JONES:
 23 A. That's right.
 24 CHAYTOR, Q.C.:
 25 Q. But the issue of specimens being left without

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1 adequate formalin fixation, did you ask Maria
 2 was that happening?
 3 MS. JONES:
 4 A. In the sense of, okay, has anything been
 5 brought forward to your--basically, she would
 6 have said "we have done this procedure for
 7 years. We teach it as part of our orientation
 8 and nobody has brought issues to our
 9 attention." So in that--in responding to
 10 that, then she would have been responding to
 11 whether in fact there had been issues with
 12 inadequate fixation.
 13 CHAYTOR, Q.C.:
 14 Q. So you are the person who ultimately would be
 15 responsible for the program. Were you
 16 satisfied by the responses that you got from
 17 Maria Tracey on this issue?
 18 MS. JONES:
 19 A. Yes, I was.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and so her response to you was "well,
 22 we've been doing this for a number of years
 23 and nobody's brought it to our attention that
 24 there's been anything inadequate in what we're
 25 doing?"

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1 MS. JONES:
 2 A. That's right.
 3 CHAYTOR, Q.C.:
 4 Q. And those were her responses?
 5 MS. JONES:
 6 A. That's right.
 7 CHAYTOR, Q.C.:
 8 Q. And whether or not there was a written
 9 protocol or policy in place as to how to deal
 10 with breast specimens, in terms of the amount
 11 and type of formalin, you're not aware of
 12 that?
 13 MS. JONES:
 14 A. I'm not aware of that, and I wouldn't have to
 15 because it's a very specific operating room
 16 policy. That would be something that the
 17 division managers and program directors would
 18 sign off on, would not come to a higher level.
 19 CHAYTOR, Q.C.:
 20 Q. So would you expect though that there would be
 21 such a protocol in place?
 22 MS. JONES:
 23 A. I would expect lots of--that there would have--
 24 --that people would have been orientated to
 25 what for particular specimens would have been,

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1 so part of an orientation. In terms of
 2 working in that environment, given that that
 3 was the type of work that you do every single
 4 day.
 5 CHAYTOR, Q.C.:
 6 Q. And obviously they deal with hundreds of
 7 different specimens.
 8 MS. JONES:
 9 A. That's right.
 10 CHAYTOR, Q.C.:
 11 Q. So would it be good practice that you would
 12 expect that to be reduced to written protocol?
 13 MS. JONES:
 14 A. I would expect that there would be some
 15 protocol written around, because there are
 16 some specimens that are dry specimens and some
 17 specimens that are fixed specimens. So I'm
 18 sure that that exists.
 19 CHAYTOR, Q.C.:
 20 Q. You would expect that there would be something
 21 in writing, otherwise you have a new person
 22 coming through being oriented and not having
 23 anything other than their memory to rely on if
 24 there's nothing in writing?
 25 MS. JONES:

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1 A. Yeah, and that's why I say I would expect that
 2 the dry versus the fixed specimens would very
 3 well be written.
 4 CHAYTOR, Q.C.:
 5 Q. And whose responsibility is it ultimately to
 6 see that those protocols or SOPs are in place?
 7 MS. JONES:
 8 A. That would be the program director.
 9 CHAYTOR, Q.C.:
 10 Q. Program director, who at that point in time
 11 was who?
 12 MS. JONES:
 13 A. It was Maria Tracey.
 14 CHAYTOR, Q.C.:
 15 Q. And who does Maria Tracey report to?
 16 MS. JONES:
 17 A. She reports, in this instance, to me.
 18 CHAYTOR, Q.C.:
 19 Q. And what does it mean for Maria Tracey to
 20 report to you?
 21 MS. JONES:
 22 A. That whatever she needs to do to ensure that
 23 her program is operating, that she has those
 24 policies, procedures in place, any
 25 interactions that she need in preparation for

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1 budget, for those kinds of things, that I
 2 would be aware of, any issues that she has
 3 that were not able to be resolved at her level
 4 that needs senior executive involvement across
 5 portfolios, in fact that I would be involved
 6 in that. That she has responsibility for
 7 ensuring that she stays on budget, okay. If
 8 she's not able to stay on budget, then what is
 9 the variance and the explanation for that.
 10 That she's responsible for ensuring that
 11 equipment and that that is used in her
 12 operating rooms is up and functioning, that
 13 her staff are educated and that they're
 14 licensed to be able to do their work.
 15 CHAYTOR, Q.C.:
 16 Q. And if Maria Tracey hasn't done any element of
 17 her job or hasn't done it adequately, whose
 18 responsibility is that?
 19 MS. JONES:
 20 A. I would end up having to discuss that inside
 21 performance appraisals. We would have monthly
 22 reports. She would be--have objectives for
 23 the run of a year that we would evaluate as we
 24 move forward and being in line with the
 25 strategic plan. So I would be doing a yearly

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1 evaluation.
 2 CHAYTOR, Q.C.:
 3 Q. And this issue as to whether or not there were
 4 any written SOPs or anything, whether or not
 5 the adequacy of the SOPs, has that been an
 6 issue that you've addressed with Maria Tracey?
 7 MS. JONES:
 8 A. No, it hasn't.
 9 CHAYTOR, Q.C.:
 10 Q. And do you know--and you don't know the
 11 answer, whether or not there were or were not
 12 such written policies in place?
 13 MS. JONES:
 14 A. No.
 15 THE COMMISSIONER:
 16 Q. Wherever there is a convenient spot, we can
 17 take the morning break.
 18 CHAYTOR, Q.C.:
 19 Q. Actually, this might be a good spot, thank
 20 you.
 21 THE COMMISSIONER:
 22 Q. All right then. Take 15 minutes.
 23 (BREAK)
 24 THE COMMISSIONER:
 25 Q. Please be seated. Ms. Chaytor.

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1 CHAYTOR, Q.C.:
 2 Q. Thank you, Commissioner. Commissioner, I have
 3 a number of other exhibits that we will be
 4 referring to.
 5 THE COMMISSIONER:
 6 Q. Okay.
 7 CHAYTOR, Q.C.:
 8 Q. And those weren't ready--I apologize, those
 9 weren't ready earlier this morning, or have
 10 just come up. There is P-0776, P-0777, P-
 11 0778, actually it goes right through to P-
 12 0830. So it's 0776 through to 0830--sorry,
 13 see if this is right. No, that's wrong. It's
 14 0776. My note says 0776, 0777, 0778, 0779,
 15 and that must be 0800, yes.
 16 REGISTRAR:
 17 Q. 0780.
 18 CHAYTOR, Q.C.:
 19 Q. I'm sorry, 0780. My note says 080, so yes,
 20 0780, 0781, through to 0783. 0782, 0783.
 21 Have an extra zero.
 22 THE COMMISSIONER:
 23 Q. Okay. So in effect what you're seeking to
 24 have admitted are Exhibits P-0776 through to
 25 0783 inclusive?

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1 CHAYTOR, Q.C.:
 2 Q. That's correct. Thank you.
 3 THE COMMISSIONER:
 4 Q. Okay.
 5 EXHIBITS ENTERED AND MARKED P-0776 THROUGH P-0783
 6 CHAYTOR, Q.C.:
 7 Q. And these are documents which obviously have
 8 been disclosed to the parties, but were not
 9 included in the exhibits for Ms. Jones, or
 10 some or all of them may not have been. So we
 11 will have hard copies for the parties this
 12 afternoon.
 13 THE COMMISSIONER:
 14 Q. All right.
 15 CHAYTOR, Q.C.:
 16 Q. They'll get them lunch time.
 17 THE COMMISSIONER:
 18 Q. Thank you.
 19 CHAYTOR, Q.C.:
 20 Q. Ms. Jones, when we left, we were looking at
 21 Exhibit 0729.
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And I just--I want to understand the context

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1 then and what was happening in terms of this
 2 issue from your point of view, at the time you
 3 would have received this letter, September
 4 29th 2005.
 5 MS. JONES:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And you know at this point in time, obviously,
 9 we've looked at the executive management
 10 meeting minutes and you're aware that there
 11 is--you're aware of the scope of the problem.
 12 You're looking at a ten-year review of tests.
 13 It's many, many hundreds or certainly a lot of
 14 patients involved.
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And you'd be aware of that at the time, and
 19 they involve patients obviously all over the
 20 province, because -
 21 MS. JONES:
 22 A. That's right.
 23 CHAYTOR, Q.C.:
 24 Q. - the minutes referred to waiting for the
 25 samples to come in from other regions, and

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1 this letter would have been telling you that
 2 the external reviewers who came in here
 3 identified fixation as a problem. That's
 4 correct?
 5 MS. JONES:
 6 A. Yes, from the exit interviews, this letter
 7 says that.
 8 CHAYTOR, Q.C.:
 9 Q. Yes, and you would have been aware that they
 10 were in here or in to Eastern Health regarding
 11 the ER/PR issue?
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. And I'm just wondering then, when you read
 16 this, and it's not a very long letter, and in
 17 terms of samples being left or specimens being
 18 left overnight or over the weekend without
 19 adequate formalin fixation, that didn't ring
 20 any alarm bells for you?
 21 MS. JONES:
 22 A. I think that what you need to understand is
 23 that that particular issue would have had
 24 resonance probably with somebody who was
 25 working in an operating room or a lab, not

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1 necessarily every other nurse in the
 2 organization. So yes, the issue of fixation,
 3 we do understand that specimens have to be
 4 fixed, but standards would change over time.
 5 As I had indicated, when I worked in a case
 6 room, and I used the placenta, but we used
 7 placenta for genetic testing on still births
 8 and all of those kinds of things, so they were
 9 just as significant as well. So at the end of
 10 the day, what was the policy over a period of
 11 time, had the standards changed. You know,
 12 was there minimum period, was there maximum
 13 period, those kinds of things, would not have
 14 had any resonance with me. But it certainly
 15 probably had resonance with the people who are
 16 working at this and that was part of every bit
 17 of their daily work, part of the normal
 18 routine of what they do.
 19 CHAYTOR, Q.C.:
 20 Q. Yes, and that's been identified as an issue,
 21 it appears anyhow from this letter -
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. - by the external reviewers.

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. People independent of the organization who've
 5 come in have identified this as an issue.
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. And so I'm just wondering, why you didn't
 10 bring that up with Maria Tracey to ask her,
 11 "what are we doing? Are we--what policies do
 12 we have in place to make sure there is
 13 adequate formalin fixation?"
 14 MS. JONES:
 15 A. I think that what you need to hear me say and
 16 what I would have said to Maria is "the
 17 bookings can't happen, and what are the other
 18 issues that are there? So do whatever needs
 19 to be done," in like that way. I had worked
 20 with Maria for well over ten years, so when I
 21 would say to Maria "this here is an issue.
 22 What is--you know, what's going on? Deal with
 23 Don Cook," okay, on an individual issue, and
 24 it was only if, in fact, there was any issue
 25 that she wasn't able to resolve that it would

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1 come back, and it would have come back to me
 2 and Don Cook would have brought it back to Bob
 3 Williams and then we would have had a
 4 discussion. So we never got involved at the
 5 executive level with issues that were dealt
 6 with or could be dealt with at the individual
 7 program director level. In this instance what
 8 you had was an individual physician, a lab
 9 program actually dictating to a peri-operative
 10 program how to do its work, that can't happen
 11 because if we're to flow everything through,
 12 then they have to work in concert. What they
 13 did do was find a way around the issue that
 14 Dr. Cook had identified -
 15 CHAYTOR, Q.C.:
 16 Q. On a go forward in terms of -
 17 MS. JONES:
 18 A. On a go forward basis -
 19 CHAYTOR, Q.C.:
 20 Q. - scheduling the ORs -
 21 MS. JONES:
 22 A. Absolutely.
 23 CHAYTOR, Q.C.:
 24 Q. - yes, I understand that. But I'm just
 25 wondering about what about what had already

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1 happened and the fact that the external
 2 reviewers are identifying this fixation issue,
 3 I'm wondering what happened in terms of then
 4 your discussions to find out if, in fact, this
 5 was an issue and why it was an issue in the
 6 peri-operative program?
 7 MS. JONES:
 8 A. And I think that I've kind of answered that
 9 question in being that if there were issues
 10 with respect to fixation, then that would have
 11 come back to the individual program at the
 12 time that the issue had arisen and it had not
 13 been brought forward. I don't know because
 14 it's not an area that I would have full
 15 familiarity with, whether there had been a
 16 change in fixation, whether there, in fact,
 17 had been a period of time because I do
 18 understand that, in fact, fixation has to be
 19 for a certain period of time, in some of these
 20 specimens for three hours, no more than 24,
 21 those kinds of things. Whether they were
 22 standards in the year 1997 or had evolved over
 23 time with particular issues with respect to
 24 breast specimens, that I think you really need
 25 to talk to the people in the area that were

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1 looking at fixation. Maybe, maybe it was
 2 acceptable to leave them overnight. It had
 3 never been brought to our attention before.
 4 Maybe in today's standards maybe there is new
 5 benchmarks or new guidelines.
 6 CHAYTOR, Q.C.:
 7 Q. But it wouldn't, I take it, be acceptable to
 8 ever leave them without adequate formalin
 9 fixation?
 10 MS. JONES:
 11 A. Yes. And the question is what was adequate
 12 formalin fixation. My background knowledge in
 13 nursing would basically say that the tissue
 14 had to be covered.
 15 CHAYTOR, Q.C.:
 16 Q. Right.
 17 MS. JONES:
 18 A. And that was the extent of it.
 19 CHAYTOR, Q.C.:
 20 Q. And did you ask Maria whether or not that, in
 21 fact, was happening?
 22 MS. JONES:
 23 A. I'm sure that Maria would not have actually
 24 had that level of detail because that would
 25 have been the standard, the orientation that

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1 that is, in fact, how you put specimens in,
 2 that they had to be covered.
 3 CHAYTOR, Q.C.:
 4 Q. My question is whether or not you asked -
 5 MS. JONES:
 6 A. I would not have asked -
 7 CHAYTOR, Q.C.:
 8 Q. - that of Maria?
 9 MS. JONES:
 10 A. - that question. I would have said, "Is there
 11 an issue?"
 12 CHAYTOR, Q.C.:
 13 Q. You would have said, "Is there an issue with
 14 the adequacy of the fixation, the amounts or
 15 types or whatever? What could this mean?"
 16 MS. JONES:
 17 A. Yeah.
 18 CHAYTOR, Q.C.:
 19 Q. Did you ask her those questions?
 20 MS. JONES:
 21 A. I would have said to her, "Are you aware,"
 22 like I said to you, "Are you aware of any
 23 issues that have been brought to your
 24 attention with respect to fixation."
 25 CHAYTOR, Q.C.:

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1 Q. Whether or not the lab had brought the issue
 2 to their attention -
 3 MS. JONES:
 4 A. Or whether, in fact, she was aware of it.
 5 CHAYTOR, Q.C.:
 6 Q. Right. Whether or not she was aware of
 7 whether or not there was an issue?
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. In terms of adequacy of the fixation?
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. You asked her that?
 16 MS. JONES:
 17 A. Yes, I would have asked that. There's two
 18 issues in this letter and those -
 19 CHAYTOR, Q.C.:
 20 Q. Yes, the scheduling is the one that you said,
 21 you know, immediate -
 22 MS. JONES:
 23 A. That would -
 24 CHAYTOR, Q.C.:
 25 Q. - you thought of -

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1 MS. JONES:
 2 A. That would have been the immediate -
 3 CHAYTOR, Q.C.:
 4 Q. - that that couldn't happen?
 5 MS. JONES:
 6 A. That couldn't have happened.
 7 CHAYTOR, Q.C.:
 8 Q. Right. But I'm just interested now in the
 9 issue of that was going to be the solution to
 10 the problem. The scheduling of the ORs was
 11 being put forward by Dr. Cook as something he
 12 was strongly recommending as the solution to
 13 the problem. But the actual problem itself,
 14 I'm wondering what inquiries you made to
 15 figure out how that could have been the case?
 16 MS. JONES:
 17 A. And what I do know is that the specimen
 18 bottles, okay, because this was brought back
 19 to me, the specimen bottles on biopsies were
 20 increased in size, okay. So there was a
 21 direct response back on what we actually did.
 22 CHAYTOR, Q.C.:
 23 Q. Right. And so in terms of what was happening
 24 in the past, what were you able to ascertain
 25 in terms of what was happening and whether or

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1 not it was up to standard?
 2 MS. JONES:
 3 A. Well, I would say to you that the specimen
 4 bottles that we were using for biopsies had
 5 been used for significant period of time,
 6 okay. And through this process at the end of
 7 the day they had agreed that they needed
 8 larger specimen bottles. So if that was the
 9 case, then I--and the specimens would have
 10 been in that particular bottle, then it would
 11 have been covered with formalin. I, you know,
 12 that is the extent of what I know about it.
 13 CHAYTOR, Q.C.:
 14 Q. And in terms of what Maria told you about
 15 whether or not there was adequate amounts of
 16 formalin being used, what did she tell you?
 17 MS. JONES:
 18 A. I have no recall on adequate amounts of
 19 formalin.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. So the adequate formalin fixation
 22 that's referred to here, did you have any
 23 discussions with her on that?
 24 MS. JONES:
 25 A. I think I would just go back to saying the

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1 same thing. I would have said to her, "What
 2 is the issue here?" okay, "Is there an issue?"
 3 She wasn't aware of an issue. To check it
 4 down and check it out and at the end of the
 5 day there was a decision to move to a larger
 6 biopsy, bottle for biopsies, all right. And
 7 so -
 8 CHAYTOR, Q.C.:
 9 Q. So you didn't actually -
 10 MS. JONES:
 11 A. - that's all I can say.
 12 CHAYTOR, Q.C.:
 13 Q. - get to saying, "Well, Maria, what are we
 14 doing right now? What is it? Show me
 15 whatever protocols or tell me whatever
 16 protocols are in place and let's see how that
 17 compares to" -
 18 MS. JONES:
 19 A. And I would not have -
 20 CHAYTOR, Q.C.:
 21 Q. You wouldn't do that?
 22 MS. JONES:
 23 A. That would not have--at the COO level or the
 24 executive level that would never have been the
 25 level of detail that we would have been asking

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1 on any policy or any procedure. You would
 2 have a program director who would be
 3 responsible for insuring that they understood
 4 what was going on in their area and then
 5 having the policies or working out the issues
 6 that they had.
 7 CHAYTOR, Q.C.:
 8 Q. Yes. And how did you assure yourself that
 9 that, in fact, was happening?
 10 MS. JONES:
 11 A. Through the follow-up meetings with her. I
 12 would have had this particular letter in her
 13 file every month when I met with her and as we
 14 go through the monthly meeting, anything that
 15 was there I would have said, "Now, is this
 16 resolved?" And so that would have been the
 17 way that I deal with my program directors in
 18 terms of ongoing resolution of issues that
 19 might be there and it's always a come-forward
 20 file, okay. So I look at my notes from the
 21 last time, as well as what's in the file, and
 22 say, "What was actually done?"
 23 CHAYTOR, Q.C.:
 24 Q. And I understand that and I understand that,
 25 you know, you have to be at a certain level.

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1 But when an issue comes to your attention that
 2 involves potentially hundreds of patients and
 3 there's an issue identified by people external
 4 to your organization which fits within your
 5 area of responsibility and the person who is
 6 responsible, you're tell me, the program
 7 director, would be responsible for making sure
 8 -
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. - that the proper procedures were in place.
 13 MS. JONES:
 14 A. Absolutely.
 15 CHAYTOR, Q.C.:
 16 Q. I'm wondering then, a problem has happened,
 17 what would your responsibility be to oversee
 18 or see that, in fact, she has done her job
 19 properly?
 20 MS. JONES:
 21 A. And, in fact, that was done by what I have
 22 just explained to you, by identifying it,
 23 talking to her, and asking her at the end of
 24 the day if, in fact, they resolved their issue
 25 with Dr. Don Cook and, in fact, what was the

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1 outcome of that. This here, as you well
 2 understand, is one of many issues that were
 3 identified and whether, in fact, it was, you
 4 know, it would have--may have been a
 5 contributing factor to what had gone on, I'm
 6 not sure. But this is one issue that was
 7 brought forward that we did follow through on,
 8 that we did change the--we did change the
 9 pick-up schedule for pick up of specimens, we
 10 did change the bucket size for small
 11 specimens, not for large specimens is my
 12 understanding, and, in fact, that there is a--
 13 the practice was reinforced.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. So, Ms. Jones, if it turns out that, in
 16 fact, fixation was a significant issue in this
 17 matter, how that came to be and whether or not
 18 the practice of the peri-operative program at
 19 the time was current practice or best
 20 practice, you don't know?
 21 MS. JONES:
 22 A. I wouldn't know that. And I would expect that
 23 that practice had it changed over time, there
 24 may have been new standards, there may have
 25 been new research. And that, that then, as I

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1 had indicated right from the beginning, if in
 2 fact there was inadequate fixation, the staff
 3 in the operating room would never have known
 4 that. It would have had to come back from the
 5 lab who actually got the specimen and
 6 processed the specimen. There's no way that
 7 nurses would know whether, in fact, an actual
 8 specimen was inadequately fixed.
 9 CHAYTOR, Q.C.:
 10 Q. But in terms of knowing to have the specimen
 11 covered in formalin -
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. - they would know that?
 16 MS. JONES:
 17 A. They would know that.
 18 CHAYTOR, Q.C.:
 19 Q. They would know to do that?
 20 MS. JONES:
 21 A. That's right.
 22 CHAYTOR, Q.C.:
 23 Q. And to your knowledge was that happening?
 24 MS. JONES:
 25 A. That is too far down in the organization. I

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1 would know that people were orientated to -
 2 CHAYTOR, Q.C.:
 3 Q. So you haven't asked that?
 4 MS. JONES:
 5 A. I haven't. They would have been orientated
 6 and know that that was the process on
 7 specimens.
 8 CHAYTOR, Q.C.:
 9 Q. I understand how this cuts across portfolio
 10 and you're saying that the OR would be relying
 11 on the lab to -
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. - come back if there was any issue?
 16 MS. JONES:
 17 A. Um.
 18 CHAYTOR, Q.C.:
 19 Q. And your communication at that level would be
 20 with Dr. Williams?
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And he's responsible for the lab through the
 25 chain -

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And you sit around the same table with Dr.
 5 Williams at executive management?
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. So did you discuss this issue with Dr.
 10 Williams?
 11 MS. JONES:
 12 A. No. He would have--if, in fact, there was an
 13 issue that Maria and Dr. Cook were not able to
 14 resolve, then Maria would have brought it to
 15 me and I would have had a discussion with Bob,
 16 not necessarily inside of executive, I may
 17 have called him and said "What you were asking
 18 is can't be done," but, "and we have not been
 19 able to resolve an issue," but at the end of
 20 the day we were able to resolve an issue, so
 21 it would not have come back to us.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. So did you ever discuss this issue with
 24 Dr. Williams?
 25 MS. JONES:

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1 A. No.
 2 THE COMMISSIONER:
 3 Q. Excuse me, but there was something you said
 4 about a minute ago that I just didn't want to
 5 slip by. Maria Tracey, is that -
 6 MS. JONES:
 7 A. Yes.
 8 THE COMMISSIONER:
 9 Q. Yes. In the context of answering one of Ms.
 10 Chaytor's questions did I hear you to say that
 11 you would not expect her to have the detailed
 12 knowledge of what is required, either, is
 13 there someone below her?
 14 MS. JONES:
 15 A. There are division managers. That where the
 16 individual complaints would have been coming
 17 from the lab to her manager on the site in the
 18 operating room, either one of the operating
 19 rooms. And she would have then been apprised
 20 if there was an issue that was--that they were
 21 not able to resolve.
 22 THE COMMISSIONER:
 23 Q. Okay. So now, forgive my ancient terminology.
 24 But is a division manager what used to be the
 25 head nurse in the OR?

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1 MS. JONES:
 2 A. Yes.
 3 THE COMMISSIONER:
 4 Q. Okay. So as I understand what you were
 5 saying, is that the person who really knows
 6 what is going on vis-a-vis the lab and the OR
 7 regarding the handling of specimens, would be
 8 the head nurse in each of the individual ORs?
 9 MS. JONES:
 10 A. Absolutely.
 11 THE COMMISSIONER:
 12 Q. And it seemed to me that what you were also
 13 saying was that problems between the lab and
 14 the OR are dealt with on an individual basis?
 15 MS. JONES:
 16 A. That's right.
 17 THE COMMISSIONER:
 18 Q. What happens if the individual problem keeps
 19 getting repeated in other ORs?
 20 MS. JONES:
 21 A. Then what would happen is is that the--if
 22 there was an issue that was unable to be
 23 resolved, then it would be brought up to the
 24 program director who would deal directly with
 25 the program director for laboratory

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1 management. So we handle issues at the lowest
 2 level in the organization where they can be
 3 resolved. If they're unable to be resolved,
 4 then it would be brought up to the program
 5 director. If it couldn't be resolved at the
 6 program director, maybe it's a resource issue,
 7 whatever, then it would come up to the COOs or
 8 the VP, depending on where it was in the
 9 organization.
 10 THE COMMISSIONER:
 11 Q. What I'm thinking about probably as is obvious
 12 is that just looking at it from a perspective
 13 of one who might say, okay, what kinds of
 14 problems are there in dealing with specimens
 15 from the point that they are taken until they
 16 get to the lab.
 17 MS. JONES:
 18 A. Yes.
 19 THE COMMISSIONER:
 20 Q. Is there some method of insuring that problems
 21 which are resolved which are we don't do this
 22 with this kind of specimen or we're reminding
 23 everybody that that kind of specimen has to be
 24 done at this level is communicated from one
 25 division manager to another so you don't need

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1 it to happen five times before it gets
 2 corrected?
 3 MS. JONES:
 4 A. What you would be doing, because the program
 5 directors have meetings with their division
 6 managers, group meetings, that kind of
 7 information would be communicated in that
 8 vehicle. And if, in fact, there was a need
 9 for policy direction in terms of nursing, then
 10 those policy would be across all. So it would
 11 be the operating rooms, the adult operating
 12 rooms that that would be the same policy in
 13 the two operating rooms.
 14 THE COMMISSIONER:
 15 Q. Okay. Ms. Chaytor.
 16 CHAYTOR, Q.C.:
 17 Q. So do you know, was this an issue involving
 18 more than one site?
 19 MS. JONES:
 20 A. Yes, it would have been an issue with more
 21 than one site, because we do breast, majority
 22 of it on one site, but both, both sites do do
 23 breast surgeries.
 24 CHAYTOR, Q.C.:
 25 Q. So you indicated you hadn't had a discussion

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1 with Dr. Williams regarding this, the concerns
 2 expressed in this letter. Did you speak to
 3 anyone else other than Maria Tracey about
 4 this?
 5 MS. JONES:
 6 A. No.
 7 CHAYTOR, Q.C.:
 8 Q. And you say that measures were taken to
 9 accommodate the surgeries on a go-forward
 10 basis?
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. And the details of that and what resolution
 15 was achieved, you're not familiar with those
 16 details?
 17 MS. JONES:
 18 A. The details, as I said, was looking at bucket
 19 sizes to make sure that there was actual size
 20 appropriate to specimen. And there was also a
 21 portering schedule put in place that would
 22 allow pick ups within the particular periods
 23 of time, as well as dating and timing on
 24 specimens.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. And in terms of the scheduling of the
 2 surgeries, what resolution was reached to
 3 that?
 4 MS. JONES:
 5 A. There was, because we put in a portering pick-
 6 up system from the--from pathology forward,
 7 there was no real need to change the
 8 scheduling of the surgeries.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. And why is it again that the--Dr.
 11 Cook's recommendation wouldn't work, why
 12 couldn't they--he's suggesting that it happen
 13 first thing in the morning, that those types
 14 of surgery happen first thing in the morning
 15 and that they not take place on Fridays?
 16 MS. JONES:
 17 A. Monday to Friday, it says, the first thing in
 18 the morning. They could take place on Friday.
 19 CHAYTOR, Q.C.:
 20 Q. Right. Oh, yes.
 21 MS. JONES:
 22 A. So the reality is is -
 23 CHAYTOR, Q.C.:
 24 Q. Oh, yes, it's Friday afternoons.
 25 MS. JONES:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. Suggesting -
 4 MS. JONES:
 5 A. The reality is is that a surgeon books their
 6 OR schedule based upon how they want the flow
 7 for the day, okay. So if, in fact, we had a
 8 general surgeon who had--we have at least one
 9 surgeon who has a breast speciality, so she
 10 would be probably operating on breasts all day
 11 long. And when you talk about that, it would
 12 be either biopsies or mastectomies, okay. We
 13 have some general surgeons that do breast as
 14 well as other things, so in some of those they
 15 may very well have to be--they could very well
 16 be rearranged in that fashion, but it couldn't
 17 be accommodated across the board.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. And are the breast surgeries, the
 20 mastectomies, are they considered a large
 21 surgery, are they considered to be a large
 22 operation, a small operation?
 23 MS. JONES:
 24 A. The biopsies would be, take a lot less time
 25 than mastectomies.

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1 CHAYTOR, Q.C.:
 2 Q. Right. But in terms of the overall scheme of
 3 what happens in the OR in terms of comparing
 4 it to other procedures?
 5 MS. JONES:
 6 A. I think that what you need to talk about is
 7 what the physician profile would be. There
 8 would be a limited number of surgeons who
 9 would be doing mastectomies, okay, they would
 10 be a small profile inside of the organization.
 11 But those surgeons work on a daily basis, they
 12 don't work every single morning, they work
 13 maybe a Tuesday and a Friday morning or two OR
 14 days. So it really is the profile of the
 15 surgeon that you need to be talking about and
 16 not how many mastectomies or biopsies because
 17 it really depends on the work that they would
 18 do in the operating room in a day.
 19 CHAYTOR, Q.C.:
 20 Q. So that's the issue as opposed to -
 21 MS. JONES:
 22 A. That's the issue.
 23 CHAYTOR, Q.C.:
 24 Q. - how long the surgery takes, that's not the
 25 issue?

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1 MS. JONES:
 2 A. That's not the issue.
 3 CHAYTOR, Q.C.:
 4 Q. If we could look then, please, at P-0764?
 5 Now, Ms. Jones, P-0764 with the Eastern Health
 6 logo is a policy, it's indicated to be
 7 Fixation Policy, Medical Services
 8 (Laboratory)."
 9 MS. JONES:
 10 A. Um.
 11 CHAYTOR, Q.C.:
 12 Q. And we see "draft" written right through the
 13 document?
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. Do you know, is this policy now adopted or is
 18 it still in draft?
 19 MS. JONES:
 20 A. I can't tell you whether it is adopted
 21 formally, but I can tell you that this is the
 22 one that we are using.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. So whether there's a formal, the
 25 written policy adopted, you're not sure of,

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1 but this, in fact, what's written here -
 2 MS. JONES:
 3 A. Is the practice.
 4 CHAYTOR, Q.C.:
 5 Q. - is now the practice?
 6 MS. JONES:
 7 A. That's right.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. And it's now, it's now almost three
 10 years since the external reviewers would have
 11 raised this issue?
 12 MS. JONES:
 13 A. Um.
 14 CHAYTOR, Q.C.:
 15 Q. And you're not able to say whether or not the
 16 formal policy has been adopted?
 17 MS. JONES:
 18 A. I think that what you'll see here is the new
 19 templates that we have for policy direction
 20 because in the top corner you have med lab
 21 with no numbers.
 22 CHAYTOR, Q.C.:
 23 Q. Yeah.
 24 MS. JONES:
 25 A. So this is the move from an old policy format

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1 into the new policy format. And the -
 2 CHAYTOR, Q.C.:
 3 Q. So do you know if this was, in fact, the
 4 policy at the time in 2005 when the issue was
 5 detected?
 6 MS. JONES:
 7 A. I would say that this a change in policy
 8 because there are some very distinct, if you
 9 go to the bottom of this.
 10 CHAYTOR, Q.C.:
 11 Q. Yes.
 12 MS. JONES:
 13 A. There are some very distinct references to
 14 policies here.
 15 CHAYTOR, Q.C.:
 16 Q. And Catherine Parnell is the quality
 17 management coordinator, she's fairly new in
 18 that position?
 19 MS. JONES:
 20 A. I don't know who Catherine Parnell is, okay.
 21 CHAYTOR, Q.C.:
 22 Q. You don't know who she is in your
 23 organization?
 24 MS. JONES:
 25 A. No.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. So she's--so this is--whether or not
 3 this--you do say this is a new policy or
 4 they're certainly changes to the policy?
 5 MS. JONES:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. And but you're not sure if it has, in fact,
 9 been adopted and when it came into being?
 10 MS. JONES:
 11 A. And whether--if you look to the bottom of that
 12 linkage, okay, it references all other
 13 policies that would have either cross
 14 reference or be referenced in this. And I
 15 note that the other policies that are here all
 16 have numbers associated with them, so
 17 therefore inside of my, what I would believe
 18 to be and it's only, you know, seeing this in
 19 the last couple of days, is is that
 20 absolutely, if these have got numbers into
 21 them, then they're assigned.
 22 CHAYTOR, Q.C.:
 23 Q. Right, yeah.
 24 MS. JONES:
 25 A. Okay. And they are policies that are in

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1 effect.
 2 CHAYTOR, Q.C.:
 3 Q. The ones that are linked here?
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Yes.
 8 MS. JONES:
 9 A. Right, which includes your fixation procedure
 10 for OR staff and your tissue handling for
 11 lymph node biopsies, frozen sections, all of
 12 those kinds of things.
 13 CHAYTOR, Q.C.:
 14 Q. Right. So this one in terms of the fixation
 15 policy medical services laboratory at least
 16 what we have here is still indicated to be
 17 draft and no numbers, you say, in the corner?
 18 MS. JONES:
 19 A. And it would probably be an over arching
 20 policy where all of the rest of them feed into
 21 in some way.
 22 CHAYTOR, Q.C.:
 23 Q. Right. So if it's the practice and this is
 24 what's being followed, why isn't it the
 25 policy, why hadn't the policy been signed off

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1 if it -
 2 MS. JONES:
 3 A. I think that you might need to ask somebody
 4 other than maybe Dr. Howell. We are in the
 5 process of reformatting all of our policies
 6 into Eastern Health policies. This obviously
 7 is in Dr. Howell's day, which is since the
 8 fall of 2006, okay. And there is probably a
 9 predecessor policy that still sits in place.
 10 CHAYTOR, Q.C.:
 11 Q. Yes.
 12 MS. JONES:
 13 A. Okay. And the way that we work is is that all
 14 previous policies are in place until they are
 15 overridden by a new regional Eastern Health
 16 policy.
 17 CHAYTOR, Q.C.:
 18 Q. Okay. So if this policy hasn't been adopted,
 19 how would the nurses and the other people in
 20 the system, how would they know that this is
 21 the practice and not the old policy?
 22 MS. JONES:
 23 A. Well, if you look at the linkages here, you've
 24 got fixation procedures.
 25 CHAYTOR, Q.C.:

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1 Q. Yes.
 2 MS. JONES:
 3 A. And I would suspect maybe that if you look at
 4 those policies, that they would have
 5 components that are in here. This is an
 6 overall policy.
 7 CHAYTOR, Q.C.:
 8 Q. Right.
 9 MS. JONES:
 10 A. That talks about the overview and then a
 11 policy statement, all right.
 12 CHAYTOR, Q.C.:
 13 Q. Okay.
 14 MS. JONES:
 15 A. And then the purpose of the statement.
 16 CHAYTOR, Q.C.:
 17 Q. And it says that the overview is "Fixation is
 18 the most important step for paraffin-embedded
 19 human tissues."
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. "Inadequate fixation may adversely affect
 24 proper assessment, diagnosis,
 25 immunohistochemistry procedures and

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1 interpretation. Inadequate fixation includes
 2 under and over fixation of tissues in
 3 formalin." And then there's a comment on
 4 safety precautions.
 5 MS. JONES:
 6 A. Yeah.
 7 CHAYTOR, Q.C.:
 8 Q. And if we come down under "Policy," "All
 9 tissues requiring formalin fixation must be
 10 placed in formalin as soon as possible an no
 11 later than 30 minutes after removal from the
 12 body. Small tissue samples such as biopsies
 13 must be fixed in formalin for no less than
 14 three hours and up to 24 hours before
 15 processing."
 16 MS. JONES:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. And then the larger tissues.
 20 MS. JONES:
 21 A. Twenty-four and forty-eight.
 22 CHAYTOR, Q.C.:
 23 Q. Twenty-four to forty-eight hours before
 24 processing. And then we have in bold, "If the
 25 appropriate fixation time is not met, the

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1 following statement will be attached to this
 2 final specimen report, 'Pathology results may
 3 be adversely affected due to improper tissue
 4 fixation.'"
 5 MS. JONES:
 6 A. Um.
 7 CHAYTOR, Q.C.:
 8 Q. And then if we come down under "Procedure",
 9 it's very specific in terms of ten percent
 10 buffered formalin?
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. "If a breast specimen is removed after regular
 15 hours, call the pathologist on call."
 16 MS. JONES:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. So I take it this must be instructions being
 20 given to people in the OR?
 21 MS. JONES:
 22 A. That's right.
 23 CHAYTOR, Q.C.:
 24 Q. Right, okay. And "The date and time of
 25 fixation must be documented on the

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1 requisition."
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. Okay. And you're saying the status of this
 6 particular document, Dr. Howell would be the
 7 person who could better answer our questions?
 8 MS. JONES:
 9 A. Better answer the questions about that and all
 10 of the other supporting documents as to at
 11 what point in time they were adopted, okay.
 12 And this would have been the practice that was
 13 discussed and agreed upon as the organization
 14 moved forward with this fixation issue, okay.
 15 The on call, call the pathologist, no more
 16 than, dating and how many of the individual
 17 elements that are in this would have been in
 18 previous direction and practice.
 19 CHAYTOR, Q.C.:
 20 Q. You -
 21 MS. JONES:
 22 A. I can't speak to that.
 23 CHAYTOR, Q.C.:
 24 Q. You haven't had that conversation with anyone
 25 or done that check?

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1 MS. JONES:
 2 A. No.
 3 THE COMMISSIONER:
 4 Q. Just as a matter of curiosity, would policy
 5 such as this now be communicated via computers
 6 or are there paper copies in rooms or how are
 7 these things communicated to people now?
 8 MS. JONES:
 9 A. This here, when we get a policy approved,
 10 okay, we do not have a computerized system,
 11 okay, to do that. We will send out policies.
 12 We're still working from a paper-based system.
 13 THE COMMISSIONER:
 14 Q. Um-hm.
 15 MS. JONES:
 16 A. We have had a review as we've gone into
 17 Eastern Health with respect to software and
 18 that with respect to moving forward with a
 19 computerized system and a full library and a
 20 logging and all of that kind of thing. And we
 21 haven't gone down that road at this point in
 22 time because of the cost associated with it.
 23 And you would see it probably--we looked at
 24 Trim software as being one of the kinds of
 25 vehicles that we would use. So right now we

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1 have an individual who works inside the senior
 2 planning office that is responsible for policy
 3 and procedure redevelopment from the
 4 templates, from the numbering system, from
 5 cataloguing, from maintaining; we have a
 6 policy committee that reviews all global
 7 policies to make sure that they're consistent
 8 in that; and we have a policy framework. But
 9 the individual, we would still have individual
 10 books like this and we would have
 11 responsibility for the managers in the areas
 12 to remove all policies, put new policies in
 13 and in many of the areas you would have a
 14 sign-in kind of sheet once a new policy is in
 15 to make sure that staff have actually read the
 16 policy and are aware of the policy. And
 17 depending on the nature of the policy, we
 18 would have in-service education, as well.
 19 THE COMMISSIONER:
 20 Q. There are computers in each of your sections
 21 in the hospital, are there not?
 22 MS. JONES:
 23 A. Yes, but not covered by all staff. Because if
 24 we're talking about policy, procedure for
 25 certain types of staff that we would have,

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1 they wouldn't have access to individual kinds
 2 of computers. Some of your group departments
 3 wouldn't have those kinds of access. So
 4 that's what--we do have computers, yes, in
 5 every area.
 6 THE COMMISSIONER:
 7 Q. Um-hm.
 8 MS. JONES:
 9 A. But not so that they're readily accessible for
 10 certain types of staff.
 11 THE COMMISSIONER:
 12 Q. Ms. Chaytor.
 13 CHAYTOR, Q.C.:
 14 Q. Yes. Ms. Jones, this document seems to speak
 15 specifically or the two examples that it gives
 16 is it gives the example of breast.
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And I believe it mentions colon as well, for
 21 larger tissues such as breast and colon?
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And of course, under the procedure, it

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1 specifically refers to "a breast specimen
 2 removed after regular hours, call the
 3 pathologist on call."
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. So it seems to speak specifically to breast
 8 specimens of a larger nature in any event, as
 9 to perhaps biopsies. Do you know, did this
 10 policy--has this policy come about or the
 11 drafting of this policy come about as a result
 12 of the ER/PR issue?
 13 MS. JONES:
 14 A. I can't speak to that specifically, but I
 15 would anticipate given that you've got things,
 16 such as three to 24 hours, greater than 24
 17 hours in here, and if you look at the linkages
 18 down here, there are many other kinds of
 19 specimens that are listed.
 20 CHAYTOR, Q.C.:
 21 Q. Yes.
 22 MS. JONES:
 23 A. And basically what this particular policy will
 24 say is the procedure around the formula, okay,
 25 and then the handling and then it specifically

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1 speaks about breast because I would suspect
 2 and not having a real knowledge in this area,
 3 that there have been some change in standards
 4 or some understandings now in latter years or
 5 even in the last couple of years, that talks
 6 about this three verses 24 hours, which may
 7 not be as sensitive for other kinds of things,
 8 like limbs or kidney biopsies or those kind of
 9 things.
 10 CHAYTOR, Q.C.:
 11 Q. And when that change in standard came into
 12 being and whether or not the practice at
 13 Eastern Health was in keeping with the timing
 14 of the change in standards, you don't know?
 15 MS. JONES:
 16 A. I have no idea and I would suspect that if we
 17 were to ask the reviewers here, that is one of
 18 the things that they had brought forward.
 19 Maybe there was new literature that talks
 20 about particular breast specimens, but that
 21 would be really for Dr. Banerjee and then to
 22 have said and whether it was in the literature
 23 before that, I can't answer that.
 24 CHAYTOR, Q.C.:
 25 Q. And none of the linkages speak specifically to

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1 mastectomies, we have pathology, tissue
 2 handling, breast specimen, needle,
 3 localization, but nothing other than this,
 4 what you're calling the overall policy, this
 5 one seems to speak specifically to the
 6 mastectomy.
 7 MS. JONES:
 8 A. There's one reference in here to that, yes.
 9 CHAYTOR, Q.C.:
 10 Q. Two.
 11 MS. JONES:
 12 A. Two, is there?
 13 CHAYTOR, Q.C.:
 14 Q. Well we have the one where it talks about the
 15 larger specimen, such as breasts and colon.
 16 MS. JONES:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. And then we have the actual calling the
 20 pathologist on call if it's after hours -
 21 MS. JONES:
 22 A. For breast, specifically.
 23 CHAYTOR, Q.C.:
 24 Q. For a breast specimen, yes, breast
 25 specifically. If this isn't in, hasn't been

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1 adopted, are you able to say why not?
 2 MS. JONES:
 3 A. I would think that it is in a process of many
 4 policies that are in draft development.
 5 CHAYTOR, Q.C.:
 6 Q. Right, but given the issue that came out here,
 7 the ER/PR issue, why wouldn't this policy be
 8 given a priority?
 9 MS. JONES:
 10 A. I can't answer that, you'll have to ask Dr.
 11 Howell about where this is in the line up on
 12 his policy for and given that he has, if you
 13 look to the top, he is the issuing authority
 14 because it's not just a lab. We assign
 15 individuals for certain kinds of policy and
 16 obviously this one has been assigned to Dr.
 17 Howell.
 18 CHAYTOR, Q.C.:
 19 Q. And who now has the responsibility for the
 20 peri-operative program?
 21 MS. JONES:
 22 A. Norman Baker.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, I'd just like to move on, October 5th,
 25 2005, which would be exhibit 0486, page 43. I

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1 believe this is the next executive management
 2 meeting.
 3 MS. JONES:
 4 A. Okay.
 5 CHAYTOR, Q.C.:
 6 Q. And if we look at the--sorry, go back to the
 7 beginning, here we go. And Mr. Tilley is
 8 chairing the meeting, I guess, and you're not
 9 actually at this one, you have regrets given.
 10 MS. JONES:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. Mr. Williams is at this one.
 14 MS. JONES:
 15 A. Okay.
 16 CHAYTOR, Q.C.:
 17 Q. Dr. Williams, I should say. And at page 43 at
 18 the bottom, we have "George Tilley commended
 19 Dr. Williams on his handling of the media and
 20 articulating the messages related to the
 21 ER/PR." So this is three days after the issue
 22 has come out.
 23 MS. JONES:
 24 A. In "The Independent", yes.
 25 CHAYTOR, Q.C.:

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1 Q. "Initially the reaction of the public to the
 2 press release was minimal; however, it has
 3 since increased." And this is Ms. Bonnell's
 4 name, I take it if your name is over in the
 5 column, you're the person tasked with the -
 6 MS. JONES:
 7 A. With either follow up because of something
 8 that's there, right, "to ensure consistency of
 9 messages all calls will be routed to"--and
 10 that would have been, yeah.
 11 CHAYTOR, Q.C.:
 12 Q. Now would you be provided copies of the
 13 minutes?
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. So even though you're not in attendance, you
 18 get your copies of the minutes.
 19 MS. JONES:
 20 A. Oh yes.
 21 CHAYTOR, Q.C.:
 22 Q. And would you read those?
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. So you would have read this to bring yourself
 2 up to date on all the issues, including the
 3 ER/PR issue?
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Yes, and it says Ms. Bonnell either reporting
 8 on this issue or being tasked with any follow
 9 up.
 10 MS. JONES:
 11 A. Follow up.
 12 CHAYTOR, Q.C.:
 13 Q. "Calls are being received through various
 14 avenues throughout the organization, including
 15 switchboard emergency and cancer clinic to
 16 ensure consistency in the messages, all calls
 17 will be routed through the patient relations
 18 officer."
 19 MS. JONES:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. "A meeting with the other health authorities
 23 in relation to the process that we are
 24 recommending to ensure a system-wide approach
 25 to the public communications are ongoing. An

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1 information website will be established on the
 2 Health Care Corporation of St. John's'
 3 webpage." Why is that not Eastern Health?
 4 MS. JONES:
 5 A. We were early in, I would suspect that
 6 somebody did not pick that up. We wouldn't
 7 have had an Eastern Health website at that
 8 point in time, I wouldn't expect, and it still
 9 would have been Health Care Corporation and
 10 this is only five, six months, it was not a
 11 priority in moving to that, I would expect.
 12 CHAYTOR, Q.C.:
 13 Q. "Dr. Laing and Pat Pilgrim are working on
 14 developing a communication strategy for
 15 physicians around the province. Dr. Williams
 16 will share with executive the current details,
 17 fact and figures from laboratory on this
 18 issue." And what did that refer to?
 19 MS. JONES:
 20 A. I guess if Dr. Williams had any--this is the
 21 facts and figures, may very well be if we look
 22 at the Mount Sinai reference there, I would
 23 expect that we still didn't have a number and
 24 we know that we didn't have them back for
 25 months, whether in fact all of the specimens

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1 that had gone forward were reported on.
 2 CHAYTOR, Q.C.:
 3 Q. "All specimens will be forwarded to Mount
 4 Sinai by Monday, October 10, 2005, with the
 5 exception of Corner Brook."
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. So Corner Brook is still not in and that looks
 10 like it's Dr. Williams.
 11 MS. JONES:
 12 A. Williams for follow up, yes.
 13 CHAYTOR, Q.C.:
 14 Q. And Pat Coish-Snow advised that there are few
 15 specimens from 1997 through 1999 from
 16 Clarenville that are being prepared and will
 17 be sent to St. John's for packaging and
 18 forwarding to Mount Sinai."
 19 MS. JONES:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. And why is it only 1997 through 1999 from
 23 Clarenville?
 24 MS. JONES:
 25 A. I probably would know it today, I wouldn't

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1 have known it at the time, but Clarenville did
 2 not use--Clarenville had sent their specimens
 3 directly to Mount Sinai for a long period of
 4 time, they were a different board a the time,
 5 so I don't know, but maybe '97 to '99 there
 6 was some work done in St. John's for
 7 Clarenville.
 8 CHAYTOR, Q.C.:
 9 Q. And so after that time period, it's your
 10 understanding now that Clarenville had already
 11 been using Mount Sinai?
 12 MS. JONES:
 13 A. Already been using Mount Sinai.
 14 CHAYTOR, Q.C.:
 15 Q. And does Clarenville continue to use Mount
 16 Sinai?
 17 MS. JONES:
 18 A. It was using Mount Sinai, we've just recently,
 19 we were doing for St. John's, and I'm thinking
 20 that both Clarenville and Carbonear are now
 21 being worked on in St. John's, but you would
 22 have to ask Dr. Howell that.
 23 CHAYTOR, Q.C.:
 24 Q. You're not sure.
 25 MS. JONES:

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1 A. I'm not absolutely sure on that point.
 2 CHAYTOR, Q.C.:
 3 Q. So Clarenville is clearly under Eastern
 4 Health's umbrella now.
 5 MS. JONES:
 6 A. That's right, and we would have been moving
 7 those that worked to Eastern Health.
 8 CHAYTOR, Q.C.:
 9 Q. And whether or not you are currently doing the
 10 ER/PR testing for Clarenville, you're saying
 11 that's Dr. Cook?
 12 MS. JONES:
 13 A. I'm thinking it's yes, because we've had
 14 conversations about at--with the lab in St.
 15 John's doing the work for St. John's and then
 16 moving Carbonear back in and Clarenville back
 17 in, but I'm thinking yes right now.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. And the next meeting, executive
 20 management, October 19th, 2005.
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. And this one you are in attendance?
 25 MS. JONES:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. But Dr. Williams is not in attendance at this
 4 meeting.
 5 MS. JONES:
 6 A. And I chaired this meeting, according to this
 7 one.
 8 CHAYTOR, Q.C.:
 9 Q. You chaired this meeting.
 10 MS. JONES:
 11 A. Yes, because Mr. Tilley wasn't in attendance.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, yes. So would you be the person, if Mr.
 14 Tilley was absent, would that be the norm,
 15 that you would be the person to step up to the
 16 plate?
 17 MS. JONES:
 18 A. Not necessarily, George would ask an
 19 individual to do it, so it could have been me
 20 today, it could have been Fay Matthews the
 21 next week if he was not there.
 22 CHAYTOR, Q.C.:
 23 Q. And in terms of his absence on any occasion,
 24 other than in the context of executive
 25 management meetings, who would be the next

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1 person, the second in charge, if you will?
 2 MS. JONES:
 3 A. He didn't have a second in charge.
 4 CHAYTOR, Q.C.:
 5 Q. So would it depend on the issue as to who
 6 would -
 7 MS. JONES:
 8 A. It depended on the issue and we would deal
 9 with the issue, so if it was in the adult
 10 acute care portfolio, I would take
 11 responsibility on that; if it was in
 12 community, it would be the COO or the VP
 13 responsible.
 14 CHAYTOR, Q.C.:
 15 Q. Okay, so on this occasion, this meeting that
 16 you chaired, the laboratory ER/PR update, who
 17 would have given the update in Dr. Williams'
 18 absence?
 19 MS. JONES:
 20 A. I can't answer that because in the previous
 21 minutes you had referenced that Pat Pilgrim
 22 was following up on a physician--with Dr.
 23 Laing and that, so there may have been points
 24 in this that others could have added to the
 25 conversation and certainly on the media

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1 campaign and I don't know if Susan Bonnell was
 2 there, but Mr. Dodge would have been there as
 3 well and they might very well have been able
 4 to--Susan wasn't there, so it would have been
 5 Steve in that instance.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and this is saying that "the
 8 organization is considering a media campaign
 9 to ensure key messages are communicated,
 10 public announcement for T.V. and print add,
 11 there is a growing awareness nationally
 12 related to our laboratory PR/ER testing."
 13 MS. JONES:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. Did that happen? Was there any T.V. -
 17 MS. JONES:
 18 A. I can't recall back that far, right, in terms
 19 of the actual flow of the communication,
 20 right.
 21 CHAYTOR, Q.C.:
 22 Q. So do you know, do you know whether or not any
 23 T.V. ads were ever run on this issue?
 24 MS. JONES:
 25 A. I wouldn't have thought T.V. ads, but sure

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1 some print ads, but I'm not sure on that
 2 because we have used print in the past, we
 3 have used some radio ads as well, more
 4 recently.
 5 CHAYTOR, Q.C.:
 6 Q. We continue on then, I think the next meeting
 7 is October 31st.
 8 MS. JONES:
 9 A. Uh-hm.
 10 CHAYTOR, Q.C.:
 11 Q. Mr. Tilley is back as chair.
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. You are in attendance, as is Dr. Williams.
 16 MS. JONES:
 17 A. Yes, and -
 18 CHAYTOR, Q.C.:
 19 Q. Sorry?
 20 MS. JONES:
 21 A. No, no, I was just checking the date there,
 22 that's fine.
 23 CHAYTOR, Q.C.:
 24 Q. October 31st?
 25 MS. JONES:

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1 A. 31st, yes.
 2 CHAYTOR, Q.C.:
 3 Q. And it appears Ms. Bonnell is also present?
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. And the update is under 1.5, Laboratory ER/PR
 8 Update. Dr. Williams is expecting additional
 9 information on test results from Mount Sinai,
 10 as more information becomes available,
 11 executive will be advised accordingly. There
 12 were several callers to the "Open Line" today
 13 related to the issue." And that's it in terms
 14 of the update given to executive given on that
 15 date.
 16 MS. JONES:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. Now, we just looked through the minutes of
 20 October 5th, October 19th, October 31st -
 21 MS. JONES:
 22 A. Uh-hm.
 23 CHAYTOR, Q.C.:
 24 Q. And previously we had looked at the September
 25 28th minutes.

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. This issue on fixation, that's not raised with
 5 the executive management?
 6 MS. JONES:
 7 A. No.
 8 CHAYTOR, Q.C.:
 9 Q. And in terms of reporting on the outcome of
 10 the external reviews, was that raised at the
 11 executive management level?
 12 MS. JONES:
 13 A. If there's nothing here to say that, then it
 14 wouldn't have been and may have been, but I
 15 don't see it there, the external reviews are
 16 back, but they weren't, I don't believe--there
 17 was exit interviews, but at that point in time
 18 the written reports, I would expect, were not
 19 back. Dr. Williams would have referenced
 20 that.
 21 CHAYTOR, Q.C.:
 22 Q. And if there's no indication in the minutes of
 23 any verbal, if there had been a verbal
 24 communication by Dr. Williams on the outcome
 25 of the reviews, would we expect to see that in

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1 the minutes?

2 MS. JONES:

3 A. You would have expected--these are not

4 verbatim minutes, as you can well appreciate,

5 but the main points that were discussed would

6 have been captured.

7 CHAYTOR, Q.C.:

8 Q. You go on to November 16th then appears to be

9 the next.

10 MS. JONES:

11 A. Uh-hm.

12 CHAYTOR, Q.C.:

13 Q. And under ER/PR 2.9 "Laboratory ER/PR Update:

14 the slow turn-around time for test results

15 from Mount Sinai is an issue. Mr. Tilley has

16 been in contact with the CEO in an attempt to

17 speed up the response time."

18 MS. JONES:

19 A. Yes.

20 CHAYTOR, Q.C.:

21 Q. And Dr. Williams is regrets, he's not in

22 attendance at this meeting.

23 MS. JONES:

24 A. Uh-hm.

25 CHAYTOR, Q.C.:

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1 Q. Do you recall that the reports of Drs.

2 Banerjee and Ms. Wegrynowski being addressed

3 at the executive management meetings in 2005?

4 MS. JONES:

5 A. Probably, no in terms of the recommendations,

6 per se, I would understand that they--Bob

7 would have indicated that the reports were

8 back, okay, and that they would have been

9 working on the recommendations.

10 CHAYTOR, Q.C.:

11 Q. So that's the extent of what would be told at

12 the executive management level?

13 MS. JONES:

14 A. Working through the recommendations.

15 CHAYTOR, Q.C.:

16 Q. Okay, and would there have been any

17 information provided to executive management

18 as to what the nature of the problem -

19 MS. JONES:

20 A. Only in a generic sense, they were deemed to

21 be peer reviews, okay, so we never did

22 physically see the recommendations and only to

23 the extent policy procedure work and the

24 recommendations as they were moving forward.

25 So Bob basically managed the file with respect

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1 to what needed to be done.

2 CHAYTOR, Q.C.:

3 Q. So what were you told in terms of in a general

4 sense, what were you told that the nature of

5 the problem--what was the nature of the

6 problem?

7 MS. JONES:

8 A. There was never any discussion about the

9 nature of the problem, there was lots of, you

10 know, discussion elsewhere, not in executive,

11 around, you know, false negativity, you know,

12 DAKO, Ventana, but they would not have been

13 discussions to be able to draw conclusion.

14 There was never any conclusion to say that

15 this is what we found, bottom line is that the

16 recommendations that came out of the report,

17 we're working our way through them.

18 CHAYTOR, Q.C.:

19 Q. So you would have been told that there was a

20 change in equipment, DAKO to Ventana.

21 MS. JONES:

22 A. We knew that, though, from the September and

23 that was one of the things that they were

24 concerned about, was there something with the

25 equipment.

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1 CHAYTOR, Q.C.:

2 Q. Right, okay. So was that ever linked to what

3 came out of the external reviews?

4 MS. JONES:

5 A. There was nothing that we knew of the external

6 reviews because we didn't physically see them.

7 CHAYTOR, Q.C.:

8 Q. Right.

9 MS. JONES:

10 A. And it wasn't discussed at executive.

11 CHAYTOR, Q.C.:

12 Q. And was this issue in terms of the equipment,

13 DAKO verses Ventana, was that an issue that

14 continued beyond the September -

15 MS. JONES:

16 A. Absolutely because it still is, in some ways,

17 a discussion that was happening between

18 pathologists and that, so you would just hear

19 it in general discussion, not inside of here.

20 CHAYTOR, Q.C.:

21 Q. So that's an issue that got brought up over

22 and over again.

23 MS. JONES:

24 A. Over and over again.

25 CHAYTOR, Q.C.:

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1 Q. And the issue too, I'm sorry, you said there
 2 was something else too that was said?
 3 MS. JONES:
 4 A. Policies, you know, that--are policies not up
 5 to date, you know, not written or up to date
 6 and, you know, you could probably go in many
 7 areas where in fact, you know, there was
 8 policy work being done or not being done, you
 9 know, where there were revisions all the time,
 10 right.
 11 CHAYTOR, Q.C.:
 12 Q. And those policies including the fixation
 13 policy?
 14 MS. JONES:
 15 A. Well I would know the fixation policy because
 16 of the September issue.
 17 CHAYTOR, Q.C.:
 18 Q. So that would be one of the policies?
 19 MS. JONES:
 20 A. Yes. And there was also lots of discussion
 21 about how many steps were in the process, you
 22 know, the 40 plus steps and how could we
 23 decrease, that was part of some of the work
 24 was going on, how could we decrease the number
 25 of steps in the process.

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1 CHAYTOR, Q.C.:
 2 Q. Did anyone ever show you that or is there ever
 3 a document produced to say here is the 40
 4 steps?
 5 MS. JONES:
 6 A. No, I never ever saw it, but 40 steps,
 7 everybody is to keep talking about the 40
 8 steps and there's got to be a way to improve
 9 the process was the way it was talked about.
 10 CHAYTOR, Q.C.:
 11 Q. I take it the steps being from the time the
 12 specimen leaves the patient, 'til the specimen
 13 ends up fully processed through a slide and
 14 interpreted by a pathologist?
 15 MS. JONES:
 16 A. Interpreted, that's exactly -
 17 CHAYTOR, Q.C.:
 18 Q. So other than those things, was there ever any
 19 information given to the executive management
 20 as to what may have caused the problem?
 21 MS. JONES:
 22 A. No.
 23 THE COMMISSIONER:
 24 Q. So you mean at the end of the day, nobody came
 25 back and said by the way, it wasn't DAKO or it

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1 wasn't Ventana or it was DAKO or it was
 2 Ventana?
 3 MS. JONES:
 4 A. No, there was never any discussion to that, I
 5 would say that people would say that there
 6 were many contributing factors, but actual
 7 issue, there was never any conclusion as this
 8 particular issue on this particular day or
 9 whatever, and I don't know whether we can say
 10 that yet, but that's for us to work through.
 11 CHAYTOR, Q.C.:
 12 Q. Did anyone ask?
 13 MS. JONES:
 14 A. I think that what you need to understand is
 15 that the issue that was in front of us was how
 16 can we assure that we have a lab that is best
 17 practice and providing quality, so all of
 18 those things that either came out in the
 19 recommendations that Bob were working on, was
 20 to ensure that we had quality. There was lots
 21 of research being going on into the literature
 22 around, you know, the positivity rates, I also
 23 know that we had called around the country and
 24 nobody was collecting positivity rates at the
 25 time, you know, so there were things that we

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1 would have expected Mayo to have that when
 2 things were called forward, that others didn't
 3 have it either. So I don't believe that there
 4 was a sight on exactly what had gone on or
 5 what should have gone on.
 6 CHAYTOR, Q.C.:
 7 Q. So that kind of detail was given to you
 8 though, that the DAKO/Ventana issue, the issue
 9 of false negatives you said a few minutes ago
 10 -
 11 MS. JONES:
 12 A. Yeah.
 13 CHAYTOR, Q.C.:
 14 Q. - people tracking positivity rates, you were
 15 told all of that and who may not be.
 16 MS. JONES:
 17 A. But not necessarily inside of executive. This
 18 was, you know, if we were talking to Pat
 19 Pilgrim and the quality department were
 20 calling around just to see if, in fact--so, in
 21 terms of a report, those were the kinds of
 22 things that were--they weren't, kind of,
 23 coming in here, because nobody had had a sight
 24 on exactly what it was. They were trying to
 25 gather as much information as they could.

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1 CHAYTOR, Q.C.:

2 Q. So, whether it's through formally sitting

3 around executive management or in your

4 discussions with Ms. Pilgrim, you learned

5 those things?

6 MS. JONES:

7 A. We learned those things, but not in -

8 CHAYTOR, Q.C.:

9 Q. Are you involved in the issue?

10 MS. JONES:

11 A. No.

12 CHAYTOR, Q.C.:

13 Q. What's your involvement in the issue?

14 MS. JONES:

15 A. In this issue -

16 CHAYTOR, Q.C.:

17 Q. At this point in time.

18 MS. JONES:

19 A. At this point in time -

20 CHAYTOR, Q.C.:

21 Q. Not today, back when we're looking here now at

22 minutes.

23 MS. JONES:

24 A. I'm not involved because I don't have quality.

25 I had the peri-operative program and I didn't

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1 have the lab program.

2 CHAYTOR, Q.C.:

3 Q. And you indicate you don't know even to this

4 day if anyone has the answer as to what may or

5 may not have contributed or caused the

6 problem.

7 MS. JONES:

8 A. Yeah.

9 CHAYTOR, Q.C.:

10 Q. Okay. And have you read the reports of Dr.

11 Banerjee and Trish Wegrynowski?

12 MS. JONES:

13 A. After I took over this job I did because there

14 was some question about releasing the

15 information to the Inquiry.

16 CHAYTOR, Q.C.:

17 Q. Yes.

18 MS. JONES:

19 A. And so therefore, I needed to know what was

20 inside those reports, to move them forward.

21 CHAYTOR, Q.C.:

22 Q. And did that shed any light on the issue for

23 you as to what may have contributed or caused

24 the problem?

25 MS. JONES:

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1 A. There were many factors that were listed in

2 terms of basic policy and procedure, some

3 things even as fridges, education, quality

4 control was referenced in their

5 internal/external control. So, there were

6 many things inside of those reports. I think

7 all of them, coming together, would have

8 contributed to it.

9 CHAYTOR, Q.C.:

10 Q. And what did Dr. Banerjee say about the DAKO

11 system?

12 MS. JONES:

13 A. Well, it was clearly, in his and--I don't know

14 the words--but it was, it's not Ventana, it's

15 not DAKO or the Ventana system, I guess, was

16 what was referenced there.

17 CHAYTOR, Q.C.:

18 Q. Ventana and DAKO, both would have been

19 mentioned?

20 MS. JONES:

21 A. Yeah.

22 CHAYTOR, Q.C.:

23 Q. When you read the reports, based on what you

24 had been told up to that point in time, were

25 you surprised by the content of the reports?

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1 MS. JONES:

2 A. I think what you had there was in Trish's--and

3 I can't pronounce her last name, but -

4 CHAYTOR, Q.C.:

5 Q. We say Wegrynowski. She'll correct us when

6 she gets here, if it's now right.

7 MS. JONES:

8 A. Okay. In the technical report, a lot of

9 things around policy, procedure, education, at

10 the point in time I wasn't really, you know,

11 aware, I knew that we didn't have any

12 licensure in the province with respect to

13 pathologists. I already knew that we didn't

14 have any lab accreditation, those kinds of

15 things. And you know, those things would have

16 things that if, in fact, those kind of formal

17 processes had been gone on and reviewed, you

18 know, every two years or every three years or

19 every year, then you may very well have seen

20 more formalization of those kinds of things.

21 But I would not be aware of the actual lab

22 policies or those kinds of things. So, seeing

23 that they were either outdated, you know, or

24 standard operating procedures, you know,

25 those, you sort of say to yourself, well,

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1 shouldn't they have been there or some
 2 evidence of them in some way, should they have
 3 not been there.
 4 CHAYTOR, Q.C.:
 5 Q. And I take it you would not have been
 6 surprised, obviously, with the issue of
 7 fixation?
 8 MS. JONES:
 9 A. No, because I had already been aware of that
 10 one.
 11 CHAYTOR, Q.C.:
 12 Q. You were aware of that. What about those
 13 specifically, what Dr. Banerjee's findings
 14 were in terms of issues around the
 15 pathologists' work? Were you surprised by
 16 that?
 17 MS. JONES:
 18 A. I didn't have any reference point for
 19 pathologists. You know, you got
 20 internal/external controls, that really didn't
 21 mean anything.
 22 CHAYTOR, Q.C.:
 23 Q. But had any of that been brought to your
 24 attention or mentioned in the discussions
 25 beforehand?

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1 MS. JONES:
 2 A. No, no.
 3 CHAYTOR, Q.C.:
 4 Q. The issue of licensure in the province for
 5 pathologists -
 6 MS. JONES:
 7 A. No, yes, pathologists?
 8 CHAYTOR, Q.C.:
 9 Q. You said for pathologists.
 10 MS. JONES:
 11 A. No, technicians.
 12 CHAYTOR, Q.C.:
 13 Q. I take it you mean technologists.
 14 MS. JONES:
 15 A. Technicians, yeah.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, maybe I heard you wrong.
 18 MS. JONES:
 19 A. I might very well have said it the other way,
 20 Sandy, looking at Bernie, I probably did.
 21 CHAYTOR, Q.C.:
 22 Q. I knew there was an issue for technologists,
 23 but pathologists raised a little eye brow
 24 here. Okay. And after having read the
 25 reports, did you speak to anyone about the

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1 content?
 2 MS. JONES:
 3 A. Only to the extent of talking to Dr. Howell
 4 and saying, where are we? We had heard that
 5 the majority of the recommendations were in
 6 place or were in the process of being in
 7 place, so, where are we? What's left to be
 8 done? Okay. Because at that point in time,
 9 we had already restarted, okay, work for St.
 10 John's. So, there obviously had been a
 11 decision made to restart that particular
 12 component of the lab. Remember, the rest of
 13 the lab was functioning, it was just for that
 14 component. So, what is left outstanding and
 15 what do we absolutely need to do? So, that
 16 was the discussion that I had with Dr. Howell.
 17 The other thing was, is that we were going
 18 into an accreditation in the fall through the
 19 Canadian Council of Health Services
 20 Accreditation and the lab was going to be part
 21 of the pilot project on that. So, we would
 22 have another external body coming in other
 23 than the peer reviews that we had to look at
 24 the lab. Okay. And so we got those and the
 25 very next--once we got those reports, it was

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1 okay, you know, because there were a number of
 2 recommendations in there that still looked the
 3 same, you know, around policy and procedure
 4 and documentations.
 5 CHAYTOR, Q.C.:
 6 Q. Yes.
 7 MS. JONES:
 8 A. So, where are we with this? Are these the
 9 same ones? Because the new accreditation
 10 report was for all the lab, not necessarily
 11 just this little specific part of the lab.
 12 And then where went with the QMPLS as well on
 13 that.
 14 CHAYTOR, Q.C.:
 15 Q. Yes, in December then.
 16 MS. JONES:
 17 A. Yeah.
 18 CHAYTOR, Q.C.:
 19 Q. Yes, and I'm going to take you through the
 20 accreditation process in a little while.
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. In terms of dealing with the two external
 25 reviews, you say that and obviously you took

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1 it on yourself once you became interim CEO to
 2 see where you were in process.
 3 MS. JONES:
 4 A. Yes. And also we were early in that process
 5 around, possibly request or knowing that they
 6 would have had to be coming forward in the
 7 Inquiry or there would have been a request for
 8 them. So, not having any knowledge about what
 9 they were, it was that whole issue of peer
 10 review and protection and those kinds of
 11 things. So, not knowing what was inside of
 12 them, I needed to, at least, as in my role as
 13 CEO, and they didn't go any place else,
 14 understand that.
 15 CHAYTOR, Q.C.:
 16 Q. So, is that what spurred you to look at the
 17 reports, the fact that a request came--now,
 18 that would have been some time later because
 19 July of '07 you take your position.
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. And it's some months later that the Inquiry is
 24 looking for those documents.
 25 MS. JONES:

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1 A. But there was--if you go through--because I
 2 have been through the minutes on the
 3 executive--if you go through the latter part
 4 of July, there was discussion by the group
 5 that we had had already convened to say that
 6 the peer review documents will most likely
 7 come forward.
 8 CHAYTOR, Q.C.:
 9 Q. Yes.
 10 MS. JONES:
 11 A. And that therefore, we have to deal with that
 12 in the terms of the Inquiry and elsewhere.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, so what was that precipitated you to
 15 look at the documents?
 16 MS. JONES:
 17 A. Initially it was. Given everything else that
 18 was going on that I was into in the month of
 19 July, it would have been some time between
 20 July and September that I would have looked at
 21 those. And I can't tell you, because there
 22 was so many files on the desk at the time.
 23 CHAYTOR, Q.C.:
 24 Q. And so then you followed up with Oscar Howell
 25 and -

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. - inquiries as to where he was -
 5 MS. JONES:
 6 A. Where we were with it.
 7 CHAYTOR, Q.C.:
 8 Q. - with the implementation of the
 9 recommendations.
 10 MS. JONES:
 11 A. Absolutely.
 12 CHAYTOR, Q.C.:
 13 Q. So, that would have been some time later in
 14 July or August 2007?
 15 MS. JONES:
 16 A. Yeah, August into September by the time I got
 17 to that aspect, right.
 18 CHAYTOR, Q.C.:
 19 Q. And all the recommendations were not
 20 implemented at that point in time?
 21 MS. JONES:
 22 A. No, there still is one recommendation that is
 23 not, okay.
 24 CHAYTOR, Q.C.:
 25 Q. And what was the status in August/September

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1 2007 when you spoke to Dr. Howell? Was there
 2 more than one recommendation -
 3 MS. JONES:
 4 A. There may very well have been and they were
 5 working with those and it would have been
 6 still in the policy area, not the other
 7 technical kinds of things, as well as the
 8 piece of equipment that, the (unintelligible),
 9 whatever it is, that we haven't implemented.
 10 CHAYTOR, Q.C.:
 11 Q. Were you advised that Mr. Tilley had, prior to
 12 leaving his job, agreed to give the reports to
 13 Mr. Abbott?
 14 MS. JONES:
 15 A. No, I wasn't.
 16 CHAYTOR, Q.C.:
 17 Q. When did you learn that?
 18 MS. JONES:
 19 A. When I arrived in the office, okay, there was
 20 a letter to John Abbott as well as the peer
 21 review file sitting on the desk.
 22 CHAYTOR, Q.C.:
 23 Q. Sitting on the top of your desk.
 24 MS. JONES:
 25 A. Sitting on the top of Mr. Tilley's desk.

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1 CHAYTOR, Q.C.:

2 Q. So, you actually moved in, physically into Mr.

3 Tilley's office?

4 MS. JONES:

5 A. I moved physically into Mr. Tilley's office

6 and when I--and I'm believing that it wasn't

7 in an envelope. So, there would have been a

8 letter to John Abbott and attached were the

9 peer review documents. At this point in time,

10 John Abbott is gone and I am--Robert Thompson

11 is there. And so with no John Abbott, this to

12 me, doesn't go anywhere and Mr. Thompson

13 didn't ask for those particular reports.

14 CHAYTOR, Q.C.:

15 Q. Okay. I just want to back up a bit.

16 MS. JONES:

17 A. Yeah.

18 CHAYTOR, Q.C.:

19 Q. There's a letter sitting on your new desk.

20 MS. JONES:

21 A. On the desk, yes.

22 CHAYTOR, Q.C.:

23 Q. Signed by Mr. Tilley? Is it signed?

24 MS. JONES:

25 A. I put it back into a file. So, I just said to

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1 the secretary, just take that -

2 CHAYTOR, Q.C.:

3 Q. Okay, now, all right -

4 MS. JONES:

5 A. - and I'm thinking it is signed by George.

6 CHAYTOR, Q.C.:

7 Q. Signed by George, so what's the date on the

8 letter?

9 MS. JONES:

10 A. I have no idea, but it certainly would have

11 been before the--well, it would have been

12 before John Abbott left the Department of

13 Health. And this was a cover letter, I take

14 it, to forward the reports onto Mr. Abbott?

15 MS. JONES:

16 A. Absolutely.

17 CHAYTOR, Q.C.:

18 Q. Ms. Jones, where is that letter?

19 MS. JONES:

20 A. I'm sure that if I go back to the secretary--I

21 just said to Joyce, put that back in the file.

22 CHAYTOR, Q.C.:

23 Q. So, you could get that for us lunchtime?

24 MS. JONES:

25 A. I would say that, yeah.

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1 CHAYTOR, Q.C.:

2 Q. We've never seen that letter.

3 MS. JONES:

4 A. I have seen the letter.

5 CHAYTOR, Q.C.:

6 Q. We've never, no, we've never.

7 MS. JONES:

8 A. So, there would have been a letter and like I

9 said, no John Abbott, no Robert Thompson.

10 CHAYTOR, Q.C.:

11 Q. And is there any reason why that letter

12 wouldn't have been provided to the Commission.

13 MS. JONES:

14 A. No.

15 CHAYTOR, Q.C.:

16 Q. You don't know if your lawyer has seen it

17 either?

18 MS. JONES:

19 A. No, because I wouldn't have even thought of

20 that. It was just a letter there -

21 CHAYTOR, Q.C.:

22 Q. Okay. And Mr. Simmons apparently is

23 indicating that he hasn't seen it either.

24 MS. JONES:

25 A. Yeah.

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1 MR. SIMMONS:

2 Q. No, I might add at this point, no, I haven't

3 seen the letter either. And I know in the

4 interview process we've had some discussions

5 around this piece and I don't think it's

6 occurred to anyone to go back and look to see

7 if there had been -

8 CHAYTOR, Q.C.:

9 Q. No, I don't think--this didn't come up in

10 anyone's interview. I think we learned this

11 for the first time in Mr. Tilley's evidence

12 because this is the first time I'm hearing

13 this.

14 MR. SIMMONS:

15 Q. Well -

16 MS. JONES:

17 A. That's right and that wasn't asked of me -

18 CHAYTOR, Q.C.:

19 Q. No, that's right.

20 MR. SIMMONS:

21 Q. But there's no problem, we'll go back lunch

22 time and see if we can find it and there'll be

23 no difficulty producing that.

24 CHAYTOR, Q.C.:

25 Q. Thank you. So, there was the letter and the

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1 reports and you took them and gave them to
 2 your assistant.
 3 MS. JONES:
 4 A. Yes, I just said to Joyce, there is no John
 5 Abbott, why didn't it go? It's probably dated
 6 pretty, probably at the same time as John left
 7 the department.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. So, at the point that you're finding
 10 this, Mr. Abbott also is no longer in his
 11 position.
 12 MS. JONES:
 13 A. That's right.
 14 CHAYTOR, Q.C.:
 15 Q. Did you contact Mr. Thompson and ask him if
 16 he--that you had found this and is he
 17 interested in having the information?
 18 MS. JONES:
 19 A. No, I didn't because I knew that we--from my
 20 perspective, they were peer review. What
 21 decision Mr. Tilley had made around peer
 22 review and sharing with the department, I
 23 can't speak to that.
 24 CHAYTOR, Q.C.:
 25 Q. And did you consult with anyone else in making

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1 that decision?
 2 MS. JONES:
 3 A. Nope, that was, I'm faced with a letter to an
 4 individual who's no longer existing inside of
 5 the department and peer review that, I
 6 believe, is privileged information.
 7 CHAYTOR, Q.C.:
 8 Q. And you hadn't seen the reports that point?
 9 MS. JONES:
 10 A. And I hadn't seen the reports at that time and
 11 I didn't read them at the time.
 12 CHAYTOR, Q.C.:
 13 Q. And you're relying on whose characterization
 14 of them as peer review at that point in time?
 15 MS. JONES:
 16 A. They had been always talked about since the
 17 September of 2005 as external peer reviews.
 18 CHAYTOR, Q.C.:
 19 Q. Other than this letter to Mr. Abbott and the
 20 reports was there anything else on your desk?
 21 MS. JONES:
 22 A. Lots of stuff on the desk, but -
 23 CHAYTOR, Q.C.:
 24 Q. Okay, so it's not that this is the only thing
 25 sitting there.

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1 MS. JONES:
 2 A. No, it's not that this is the only thing
 3 that's sitting there.
 4 CHAYTOR, Q.C.:
 5 Q. But this was sitting on the top of the desk?
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. Is there anything else relevant to the ER/PR
 10 issue on the top of the desk?
 11 MS. JONES:
 12 A. No, only the issue that we have to deal with
 13 the ATTIP request from Mark Quinn with respect
 14 to the GI (phonetic) identified information
 15 that had to be dealt with in that week, as
 16 well as--no. And the rest of it would have
 17 been the Burin radiology and anything else
 18 that would have been on the CEO desk at the
 19 time.
 20 CHAYTOR, Q.C.:
 21 Q. Okay. I'm going to go back now to your role
 22 as COO.
 23 MS. JONES:
 24 A. Yes, fine.
 25 CHAYTOR, Q.C.:

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1 Q. Try and keep it chronological here. Were you
 2 ever consulted or did you provide any advice
 3 in your role as COO with respect to your
 4 responsibilities for the pastoral care and
 5 ethics with respect to the ER/PR issue.
 6 MS. JONES:
 7 A. No, the only issue there was Bob calling and
 8 saying I need a consult.
 9 CHAYTOR, Q.C.:
 10 Q. And that's Bob Williams.
 11 MS. JONES:
 12 A. That's Bob Williams.
 13 CHAYTOR, Q.C.:
 14 Q. And what was that about, when did he call you?
 15 MS. JONES:
 16 A. Well, some time in June of--made a phone call
 17 or an e-mail, phone call, I'm sure it probably
 18 was saying, Louise, we need an ethics review
 19 on this can you get Rick to set that up.
 20 CHAYTOR, Q.C.:
 21 Q. And what was the "this"?
 22 MS. JONES:
 23 A. It was that we had results of clients who had
 24 died and at the end of the day, what do we do
 25 with those, from a disclosure perspective.

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1 CHAYTOR, Q.C.:

2 Q. Now, you indicated this morning that the norm

3 would be contact your assistant, but if

4 there's some urgency then, it could be done

5 otherwise. Was there an urgency in this? Why

6 is Dr. Williams contacting your directly?

7 MS. JONES:

8 A. You need to understand Dr. Williams. Dr.

9 Williams picked up the phone many times, he

10 didn't write things. So, he would call, he'd

11 probably had never asked for an ethics consult

12 before. Being that he knew that pastoral care

13 and ethics was my area of responsibility, he

14 would call and say, this is what I've got, can

15 you get that in process? That was the extent

16 of the phone call, or the phone call and then

17 Denise, mostly likely, would have probably

18 followed up, but I can't recall that piece.

19 CHAYTOR, Q.C.:

20 Q. And did you understand from him that there was

21 any urgency to the request?

22 MS. JONES:

23 A. He needed to--he wanted to get it because we

24 did have, we did have results and the question

25 was what do we do with the results? So we

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1 were at the point in time where I expect we

2 had dealt--we had pretty much dealt with the

3 notifying patients and treatment changes and

4 those kinds of things, so this was a piece of

5 work where we had results that needed to be

6 dealt with.

7 CHAYTOR, Q.C.:

8 Q. And did you understand these were results for

9 all deceased patients?

10 MS. JONES:

11 A. No, they were not all deceased patients, I

12 knew that.

13 CHAYTOR, Q.C.:

14 Q. So he told you that.

15 MS. JONES:

16 A. Yes.

17 CHAYTOR, Q.C.:

18 Q. And did he indicate whether or not there was

19 any intention to retest all the deceased

20 patients?

21 MS. JONES:

22 A. Wouldn't have had that discussion.

23 CHAYTOR, Q.C.:

24 Q. So this was him contacting you to arrange an

25 ethical consult for the deceased patients who

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1 you did have results for.

2 MS. JONES:

3 A. Who we did have results on.

4 CHAYTOR, Q.C.:

5 Q. And how did you understand--why is it that

6 there were results for deceased patients? How

7 did that come to be?

8 MS. JONES:

9 A. I think that came about because in the initial

10 pulling together of blocks to be sent to Mount

11 Sinai, we just pulled blocks and sent them and

12 at that point in time, there was not a

13 differentiation about or check to see if in

14 fact these clients were actually--had died, so

15 in the process of pulling and trying to get as

16 much to Mount Sinai as we could, there were a

17 portion of slides that went for that period of

18 time that were negative, that we didn't know

19 that the clients were already deceased.

20 CHAYTOR, Q.C.:

21 Q. And Dr. Williams, did you ask your assistant

22 then to arrange it or did you refer him on to

23 the director of pastoral care?

24 MS. JONES:

25 A. No, I would call Rick myself and say "Rick, go

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1 talk to Bob, this is what Bob needs and he'd

2 like for you to get it done sooner, rather

3 than later."

4 CHAYTOR, Q.C.:

5 Q. And was the issue as to whether the

6 information on the deceased should be

7 disclosed and if so, to whom, is that

8 basically what the issue was?

9 MS. JONES:

10 A. Rick would have talked to Dr. Williams on that

11 himself and I would think that that was part

12 of the discussion. We already had, you know,

13 we had a policy on disclosure for the living,

14 but we hadn't had, like next to kin, who is

15 it, how do you do it, all of those kind of

16 things?

17 CHAYTOR, Q.C.:

18 Q. So were you ever contacted to give any advice

19 as to the--or to set up an ethical consult

20 regarding the disclosure piece to the living

21 patients?

22 MS. JONES:

23 A. No, because we had policy direction already in

24 there.

25 CHAYTOR, Q.C.:

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1 Q. And so your policy that was in place, was
 2 deemed to be appropriate to deal with this
 3 situation?
 4 MS. JONES:
 5 A. Yes, for that, but we didn't have any
 6 direction around this particular -
 7 CHAYTOR, Q.C.:
 8 Q. The deceased, right.
 9 MS. JONES:
 10 A. The deceased.
 11 CHAYTOR, Q.C.:
 12 Q. But it was felt that the disclosure policy in
 13 place for the living was the policy to be
 14 followed with respect--the disclosure policy
 15 was adequate and to be followed for the
 16 living.
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And so no other ethical issues came up or were
 21 brought to your attention concerning the
 22 disclosure piece to the patients.
 23 MS. JONES:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. How about to the public? Anybody approach you
 2 as to looking for an ethical consult as to
 3 whether or not this issue should be made
 4 public?
 5 MS. JONES:
 6 A. No.
 7 CHAYTOR, Q.C.:
 8 Q. If we could have 0481, I believe it is, Ms.
 9 Jones, the cover is just "Ethics Review".
 10 MS. JONES:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. And then page two, it's "Pastoral care and
 14 ethics, Department of Eastern Health, May
 15 twenty-ninth, two thousand and"--it's
 16 handwritten in "sixth"?
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. "Dr. Robert Williams from Rick Singleton and
 21 it's Re: Ethics Consult, ER/PR".
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. So I take it you've seen this document?

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1 MS. JONES:
 2 A. I have.
 3 CHAYTOR, Q.C.:
 4 Q. So what ultimately happens, were you involved-
 5 -you contacted Rick Singleton.
 6 MS. JONES:
 7 A. Uh-hm.
 8 CHAYTOR, Q.C.:
 9 Q. And were you at all involved then in arranging
 10 the ethical consult?
 11 MS. JONES:
 12 A. No, no involvement at all.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And who would--how is the group
 15 comprised? We see a number of individuals
 16 listed there, who makes the decision as to who
 17 will sit in?
 18 MS. JONES:
 19 A. Likely Dr. Singleton would have talked to Dr.
 20 Williams about who is involved in this issue
 21 and then Rick would have put a group of
 22 individuals around the table to talk about the
 23 issue based upon what was asked.
 24 CHAYTOR, Q.C.:
 25 Q. And so the people would be the people involved

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1 in the issue with -
 2 MS. JONES:
 3 A. And the issue who knew the most about the
 4 issue that they were dealing with. So you see
 5 that you have Heather Predham in risk
 6 management, you have oncologists there, you
 7 have pathologists, Dr. Natalie Bandrauk, so
 8 her name is spelled wrong there.
 9 CHAYTOR, Q.C.:
 10 Q. What's the name?
 11 MS. JONES:
 12 A. Bandrauk, she's an intensivist and an ethicist
 13 who works out of Memorial and then Rick
 14 Singleton being the facilitator. Dan Boone
 15 would have been there because we often have
 16 lawyers inside of our ethics consult,
 17 depending on who is involved with the
 18 situation and what interaction we had had with
 19 them over a period of time. So it wouldn't
 20 have been unusual for me to see a lawyer
 21 present in this particular consult.
 22 CHAYTOR, Q.C.:
 23 Q. And in what capacity would Dan Boone be
 24 involved in this issue?
 25 MS. JONES:

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1 A. Probably as, I think you go on talking about
 2 next of kin and -
 3 CHAYTOR, Q.C.:
 4 Q. But why would he have been involved in -
 5 MS. JONES:
 6 A. Because there would have been questions around
 7 who legally--who do you talk to now that the
 8 client is -
 9 CHAYTOR, Q.C.:
 10 Q. But why Dan Boone as opposed to, say, Eastern
 11 Health's corporate lawyers?
 12 MS. JONES:
 13 A. In 2006, I don't think we had corporate
 14 lawyers.
 15 CHAYTOR, Q.C.:
 16 Q. You didn't have any lawyers?
 17 MS. JONES:
 18 A. Well Donna Strong came on at some point in
 19 time.
 20 CHAYTOR, Q.C.:
 21 Q. She'd be in-house.
 22 MS. JONES:
 23 A. She'd be in-house. We took--we had a number
 24 of--we had gone out for a RFP in the old
 25 Health Care Corporation period of time where

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1 Stewart McKelvey, as well as Benson Myles,
 2 were two law firms that we in fact used, based
 3 upon different cases and then when we came in
 4 with Eastern Health, whoever the legacy board
 5 was dealing with at a particular time would be
 6 the lawyers, so we didn't really start to
 7 build any in-house counsel until the last year
 8 or so, so Dan Boone was with Stewart McKelvey
 9 and he would have been brought into many
 10 issues other than insurance issues.
 11 CHAYTOR, Q.C.:
 12 Q. I just want to be clear then, so Stewart
 13 McKelvey was your corporate lawyers, as well
 14 as the lawyer for HIROC, your insurer?
 15 MS. JONES:
 16 A. With the RFP there were two firms that
 17 actually, you can't call them preferred
 18 bidders, but there was two and based upon the
 19 skill sets that we need, we use people in
 20 Stewart McKelvey for labour law, a lot of our
 21 labour law works goes to Gus Lilly who had
 22 been working with legacy organizations for a
 23 long, long time.
 24 CHAYTOR, Q.C.:
 25 Q. And Gus Lilly is Benson Myles? Sorry, Stewart

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1 McKelvey.
 2 MS. JONES:
 3 A. Stewart McKelvey, and so -
 4 CHAYTOR, Q.C.:
 5 Q. I think Gus Bruce -
 6 MS. JONES:
 7 A. Gus Bruce, and Gus Bruce would be somebody in
 8 Benson Myles, but we had also used Jeff Benson
 9 because he had a lot of work with the legacy
 10 boards around consent and bi-laws and that, so
 11 really we had a set of lawyers that we used
 12 based upon the skills that we needed at the
 13 time and Dan would be involved with us, not
 14 necessarily from a HIROC perspective, but on
 15 lots of cases that were not HIROC as well.
 16 CHAYTOR, Q.C.:
 17 Q. But in this particular issue, he is the lawyer
 18 -
 19 MS. JONES:
 20 A. The one with the most knowledge.
 21 CHAYTOR, Q.C.:
 22 Q. Well he's the lawyer who has been appointed by
 23 HIROC to present the class action.
 24 MS. JONES:
 25 A. Yes, yes, absolutely.

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1 CHAYTOR, Q.C.:
 2 Q. And so he would have the most knowledge of the
 3 issue on that basis, I take it.
 4 MS. JONES:
 5 A. On that basis, right.
 6 CHAYTOR, Q.C.:
 7 Q. Is there any policy that outlines who should
 8 attend an ethical consult? Is there anything
 9 in writing that says that you should have
 10 people involved in the issue or you should
 11 have people from the community? Is there
 12 anything that -
 13 MS. JONES:
 14 A. There is a whole set of processes around an
 15 ethics consult and facilitation and
 16 identifying the ethical issue and how you
 17 document and all those kinds of things. So it
 18 would be very generic in that and it does say
 19 that, you know, you put the individuals around
 20 who have the most knowledge about and it can
 21 include clients or families and that, but it
 22 really is an open--it's not prescriptive in
 23 who should be there.
 24 CHAYTOR, Q.C.:
 25 Q. And was, to your knowledge was there any

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1 consideration given to having any
 2 representative from the families?
 3 MS. JONES:
 4 A. I have no idea, Rick Singleton would be the
 5 one who would probably be best placed to
 6 answer those questions.
 7 CHAYTOR, Q.C.:
 8 Q. So you weren't consulted on the composition of
 9 the group.
 10 MS. JONES:
 11 A. No.
 12 CHAYTOR, Q.C.:
 13 Q. And you wouldn't expect to be.
 14 MS. JONES:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. You wouldn't have to give approval to any -
 18 MS. JONES:
 19 A. Oh no, no. And my comment earlier on that
 20 sometimes Rick would say to me, I have a
 21 consult in mental health and it's in this kind
 22 of area, who would you, not say suggest, but
 23 you know, you'll need a social worker there or
 24 you'll need whatever, it's never been a person
 25 specific thing, it's more like what kind of

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1 individuals and if that particularly was in an
 2 area that he didn't have a lot of work on,
 3 right.
 4 CHAYTOR, Q.C.:
 5 Q. And Heather Predham from risk management
 6 versus Dan Boone, lawyer, then it's Heather
 7 Predham, risk manager.
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. Why would Heather be part of this ethics
 12 consult?
 13 MS. JONES:
 14 A. Because she was managing, for all intents and
 15 purposes, the notification.
 16 CHAYTOR, Q.C.:
 17 Q. Managing the notification -
 18 MS. JONES:
 19 A. Of the--after we had panelled the individuals
 20 who had changed, so in her area, she was the
 21 one who, from the notification of patients and
 22 the letters going out and the panel letters
 23 and those kinds of things, she was keeping the
 24 database on that.
 25 CHAYTOR, Q.C.:

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1 Q. Okay. So why would she be part of the ethics
 2 consult? She's the person who's tasked, at
 3 the end of the day, to making sure there's
 4 follow up with contact.
 5 MS. JONES:
 6 A. Yeah, and -
 7 CHAYTOR, Q.C.:
 8 Q. So why would she have to be -
 9 MS. JONES:
 10 A. She was probably also taking phone calls from
 11 families, looking for results.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, so that's your understanding?
 14 MS. JONES:
 15 A. Yeah.
 16 CHAYTOR, Q.C.:
 17 Q. So that's why she would be there?
 18 MS. JONES:
 19 A. Yeah.
 20 CHAYTOR, Q.C.:
 21 Q. And Dr. Joy McCarthy is an oncologist?
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And then we have two pathologists, Dr. Cook

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1 and Dr. Denic.
 2 MS. JONES:
 3 A. Yeah.
 4 CHAYTOR, Q.C.:
 5 Q. So why would they be there?
 6 MS. JONES:
 7 A. Cook because he was the previous clinical
 8 chief. Nash Denic is, maybe by this time, the
 9 current clinical chief, and that would be the
 10 only reason.
 11 CHAYTOR, Q.C.:
 12 Q. Okay.
 13 MS. JONES:
 14 A. As pathology.
 15 CHAYTOR, Q.C.:
 16 Q. Okay, and so why would you have pathologists
 17 sit on the ethics consult as to whether, and
 18 if so how to tell deceased patients the
 19 results?
 20 MS. JONES:
 21 A. I have no idea. That may be something that
 22 Rick will be able to answer, that question.
 23 CHAYTOR, Q.C.:
 24 Q. Okay.
 25 MS. JONES:

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1 A. But to me, that is not an unusual group, given
 2 the issue that we were talking about, right.
 3 CHAYTOR, Q.C.:
 4 Q. Dr. Joy McCarthy obviously would have patient
 5 contact. The pathologists wouldn't be having
 6 that patient contact?
 7 MS. JONES:
 8 A. No, not in that instance.
 9 CHAYTOR, Q.C.:
 10 Q. Okay, but not unusual though because they are
 11 the people who -
 12 MS. JONES:
 13 A. Who are involved in the issue.
 14 CHAYTOR, Q.C.:
 15 Q. Well, how are they involved in the issue?
 16 MS. JONES:
 17 A. Because the whole ER/PR issue itself, they
 18 would have been involved around the--just
 19 they're the directors for the laboratory at
 20 that point in time, right.
 21 CHAYTOR, Q.C.:
 22 Q. So they're the--yes, and -
 23 MS. JONES:
 24 A. And they're probably the ones that are also
 25 talking to Dr. Williams about this.

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1 CHAYTOR, Q.C.:
 2 Q. But they wouldn't be having discussions with
 3 Dr. Williams about contacting the families of
 4 the deceased.
 5 MS. JONES:
 6 A. No, but there would have been that whole issue
 7 of retesting as well.
 8 THE COMMISSIONER:
 9 Q. Sorry, are you saying that the ethical consult
 10 was not limited to the question of contacting
 11 the families?
 12 MS. JONES:
 13 A. No, I said that they would have had an
 14 interest in that particular issue of testing,
 15 okay, and that there was--at this point in
 16 time, there was no discussion about retesting
 17 everybody.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, and these are--Dr. Cook and Dr. Denic
 20 both would have been pathologists practising
 21 in the lab in the time period that was under
 22 review?
 23 MS. JONES:
 24 A. That's right, yes.
 25 CHAYTOR, Q.C.:

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1 Q. So in terms of their involvement in the issue,
 2 and of course, Dr. Cook certainly was
 3 instrumental in making sure that the review
 4 took place, but in terms of the necessity of
 5 them being at an ethical consult to determine
 6 whether, and if so how you're going to reveal
 7 the results of the deceased patients, are you
 8 able to tell us why their involvement would be
 9 necessary?
 10 MS. JONES:
 11 A. No, and that's why I said you really need to
 12 defer to the facilitator.
 13 CHAYTOR, Q.C.:
 14 Q. And the best you can think is that they were
 15 involved as the -
 16 MS. JONES:
 17 A. People who were -
 18 CHAYTOR, Q.C.:
 19 Q. - lab directors?
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. Okay, and we don't see anyone though, if
 24 there's an issue in terms of who's involved in
 25 the actual work, we don't see--Terry Gulliver

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1 is not there, the program director. There's
 2 no representative from the technologists.
 3 Would you have expected to see representation
 4 from that side of the lab work?
 5 MS. JONES:
 6 A. Not necessarily.
 7 CHAYTOR, Q.C.:
 8 Q. Why not?
 9 MS. JONES:
 10 A. It depends on what the issue was that was
 11 being discussed.
 12 CHAYTOR, Q.C.:
 13 Q. Yes, okay, so how would Dr. Cook and Dr. Denic
 14 be more relevant to that issue?
 15 MS. JONES:
 16 A. Because they were managing it, not necessarily
 17 the technologists, right, and so -
 18 CHAYTOR, Q.C.:
 19 Q. What about Terry Gulliver? He was certainly a
 20 manager of this issue as well.
 21 MS. JONES:
 22 A. But Terry managed the list more so, in
 23 creating the list of the 939, and then really
 24 was in the background. After that, it was Dr.
 25 Williams as well as Heather and that on the

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1 notification and that. So once the list was
 2 generated, then it went--a lot of Terry's work
 3 was complete.
 4 CHAYTOR, Q.C.:
 5 Q. And I take it though that also, in terms of
 6 Dr. Cook and Dr. Denic's involvement at this
 7 stage, in terms of letting the deceased know,
 8 deceased families know, I would take it most
 9 of their work had been concluded and they
 10 certainly weren't involved in notification
 11 piece in any event.
 12 MS. JONES:
 13 A. No.
 14 THE COMMISSIONER:
 15 Q. So, sorry to keep coming back to this.
 16 MS. JONES:
 17 A. No, no.
 18 THE COMMISSIONER:
 19 Q. But it's not getting through to me, I think.
 20 At this stage, you said that there was no
 21 thought of testing everybody.
 22 MS. JONES:
 23 A. That's right.
 24 THE COMMISSIONER:
 25 Q. Now so was the consult in terms of what do we

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1 do with the results for the deceased that we
 2 got, even though we might have not thought
 3 about whether we're getting deceased or not,
 4 or was it something else?
 5 MS. JONES:
 6 A. It clearly talks about we have results and
 7 what do we do with them.
 8 THE COMMISSIONER:
 9 Q. Yes, we understood, because we've had this
 10 earlier discussion this morning that you had a
 11 number of people. You just pulled blocks to
 12 get -
 13 MS. JONES:
 14 A. We just pulled blocks.
 15 THE COMMISSIONER:
 16 Q. - them to Mount Sinai, and then when they came
 17 back or at some point, in any event, after
 18 they had been sent, you realized that among
 19 those were the blocks of people who had since
 20 died.
 21 MS. JONES:
 22 A. Yes, and some died in between time.
 23 THE COMMISSIONER:
 24 Q. So then you had a block--a number of results
 25 for people who were deceased.

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1 MS. JONES:
 2 A. Yes.
 3 THE COMMISSIONER:
 4 Q. You also had a number of people who were
 5 deceased whose blocks had not been sent.
 6 MS. JONES:
 7 A. Had not been sent.
 8 THE COMMISSIONER:
 9 Q. And my understanding is that at this stage in
 10 the process, you were not intending to send
 11 those blocks?
 12 MS. JONES:
 13 A. We were not intending to send those blocks.
 14 THE COMMISSIONER:
 15 Q. So the question for the ethics group was what
 16 do we do with those results we have back that
 17 we know and also know that the persons whose
 18 blocks were retested are now deceased?
 19 MS. JONES:
 20 A. Yes.
 21 THE COMMISSIONER:
 22 Q. And that was limited to that extent?
 23 MS. JONES:
 24 A. That's right.
 25 THE COMMISSIONER:

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1 Q. It wasn't like, "and do we have a duty to go
 2 on and test others?" They didn't deal with
 3 that?
 4 MS. JONES:
 5 A. They didn't deal with that.
 6 THE COMMISSIONER:
 7 Q. All right.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. Thank you, Commissioner.
 10 THE COMMISSIONER:
 11 Q. Ms. Chaytor, wherever you can find an
 12 appropriate place. Follow your line of
 13 questioning, if you want to do so, but -
 14 CHAYTOR, Q.C.:
 15 Q. Well, it's going to be a little longer on this
 16 line of questioning.
 17 THE COMMISSIONER:
 18 Q. Okay. So do you want to break now?
 19 CHAYTOR, Q.C.:
 20 Q. We can break now or have a later lunch.
 21 THE COMMISSIONER:
 22 Q. Well, why don't we break now and return at,
 23 say, 2:05?
 24 CHAYTOR, Q.C.:
 25 Q. Okay, thank you.

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1 THE COMMISSIONER:
 2 Q. Thank you.
 3 (LUNCH BREAK)
 4 THE COMMISSIONER:
 5 Q. Please be seated. Ms. Chaytor.
 6 CHAYTOR, Q.C.:
 7 Q. Thank you, Commissioner. Ms. Jones, when we
 8 broke for lunch, we were still looking the
 9 pastoral care and ethics review.
 10 MS. JONES:
 11 A. Yes.
 12 CHAYTOR, Q.C.:
 13 Q. You had indicated that the policy or practice
 14 is that to have people who are involved in an
 15 issue involved in ethics, ethics questions
 16 which may arise regarding that issue.
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And so for example, if there were nursing
 21 issues or issues involving the quality of care
 22 given by nurses, would you expect that the
 23 nurses would be involved in an ethical
 24 consult?
 25 MS. JONES:

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1 A. It depends on what it is. You're talking about
 2 quality of care issues. Ethics consult comes
 3 from different avenues. So if that had been a
 4 family requesting a consult, then we probably
 5 would have had nurses there, or at least
 6 probably the manager for nurses, or
 7 professional practice. It depends on the
 8 nature of the issue.
 9 CHAYTOR, Q.C.:
 10 Q. Okay, and in this situation though, there were
 11 no laboratory technologists invited to
 12 participate.
 13 MS. JONES:
 14 A. That's right.
 15 CHAYTOR, Q.C.:
 16 Q. Okay, and is there any reason why they would
 17 not be represented or take part in this?
 18 MS. JONES:
 19 A. I can't speak to it. You really need to ask
 20 Dr. Singleton about how he put that group
 21 together to be around the table.
 22 CHAYTOR, Q.C.:
 23 Q. Is there thought given to having people
 24 external to Eastern Health attend, other than-
 25 -I realize there's an ethicist and a

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1 facilitator who would have distinct roles to
 2 play, but other people external to the
 3 organization take part?
 4 MS. JONES:
 5 A. There is nothing that says that that can't
 6 happen, but as I said this morning, in terms
 7 of setting up a consult and a process, it
 8 doesn't preclude individuals like that from
 9 being at the table.
 10 CHAYTOR, Q.C.:
 11 Q. And has there ever been any concern expressed
 12 or thought given to the potential for actual
 13 or perceived conflict of interest in using
 14 those who are closest to the issue?
 15 MS. JONES:
 16 A. Never have--we've not had that discussion. I'm
 17 sure as we set up the process, we really
 18 wanted to put the people around the table who
 19 knew the most about the issue and make sure
 20 that in the ethics realm that the ethics
 21 question was clear, and that's the reason why
 22 we involve an ethicist right from the
 23 beginning, because lots of times there are
 24 issues that really aren't ethical issues, and
 25 we tease those out. So we actually deal with

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1 the ethics issue at hand.
 2 CHAYTOR, Q.C.:
 3 Q. And this issue, in terms of disclosure to--or
 4 whether or not to disclose to the deceased's
 5 families, that would be an ethical issue?
 6 MS. JONES:
 7 A. Yes, it would.
 8 CHAYTOR, Q.C.:
 9 Q. That would clearly be an ethical issue?
 10 MS. JONES:
 11 A. Yes, it would.
 12 CHAYTOR, Q.C.:
 13 Q. Yes. So this issue of perceived or an actual
 14 conflict of interest in using the people
 15 closest to the issue, that has not been
 16 something that's been discussed?
 17 MS. JONES:
 18 A. No, and we would want to have the best
 19 information or the most accurate information
 20 around the table and then use a facilitator
 21 and the ethicist to work through those issues.
 22 CHAYTOR, Q.C.:
 23 Q. And what is it--in this particular fact
 24 situation, what is it in terms of the people
 25 who would have the knowledge, and in this case

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1 we have pathologists and oncologists and Ms.
 2 Predham and Mr. Boone, who are the people from
 3 within your organization, what is it in terms
 4 of their knowledge of the issue that would be
 5 necessary to address the ethical question?
 6 MS. JONES:
 7 A. Well, I think that that's where Natalie
 8 Bandrauk and Rick Singleton would come in
 9 place, in identifying the issue and then we
 10 needed, at least in this instance, from my
 11 perspective, at least from a legal
 12 perspective, what is, who is the next of kin,
 13 what is the obligation, where do we go from
 14 there. So that would have been that
 15 particular role.
 16 CHAYTOR, Q.C.:
 17 Q. So there's a legal question in play here as
 18 well, you're saying?
 19 MS. JONES:
 20 A. Yeah, there would be.
 21 CHAYTOR, Q.C.:
 22 Q. But in terms of the people, I'm just trying to
 23 think in terms of getting the factual
 24 background from the people closest to the
 25 issue. That could be provided obviously, a

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1 factual background could be provided to the
 2 panel who are to consider the ethical
 3 question. Why would it be necessary for them
 4 to actually then take part in the ethical
 5 consult to determine whether there should be
 6 disclosure of the issue?
 7 MS. JONES:
 8 A. I think that you would have to sit at many of
 9 these and I have not, but basically from the
 10 people who facilitate and the people who have
 11 been party to these discussions over the
 12 years, this is not the first time we've done
 13 something like this. We've had this kind of
 14 facilitated process versus an individual
 15 ethicist providing advice for in excess of
 16 seven or ten years or so, and this process
 17 works for us inside of the organization in the
 18 way we do things.
 19 THE COMMISSIONER:
 20 Q. Could you--I guess I misunderstood the role of
 21 the facilitator this morning.
 22 MS. JONES:
 23 A. Yes.
 24 THE COMMISSIONER:
 25 Q. Because when you were speaking earlier, I

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1 thought the role of the facilitator was to
 2 assist in this process of determining whether
 3 or not you had an ethical question.
 4 MS. JONES:
 5 A. It is that, as well as to facilitate the
 6 ethics consult itself. So the facilitator
 7 will do some of the background work, will
 8 tease out the ethics question with, in this
 9 instance, Dr. Natalie Bandrauk, and then bring
 10 the group together and then the ethicist and
 11 the facilitator make sure that they stay to
 12 the issues of the ethics and not get
 13 sidetracked, and you have the richness of the
 14 discussion that happens but they always bring
 15 it back to the ethical issue, because at the
 16 end of the day, there's lots of other issues
 17 that could be discussed in vehicles like this,
 18 but this is an ethics issue at this point.
 19 CHAYTOR, Q.C.:
 20 Q. So you have the people who have some knowledge
 21 of the background giving rise to the ethical
 22 question?
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. You have the ethicist and the facilitator?
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. And if there could potentially be legal issues
 6 involved, you usually invite a lawyer?
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And in terms of family representation, I asked
 11 you about that this morning, to your
 12 knowledge, there was no consideration given to
 13 that in this particular case?
 14 MS. JONES:
 15 A. No.
 16 CHAYTOR, Q.C.:
 17 Q. Is there any group not represented in the
 18 number who attended that you would have
 19 anticipated would have been around the table?
 20 MS. JONES:
 21 A. Really I don't see that, at this point, even
 22 retrospective looking at it. I do know from
 23 e-mails that Dr. Kara Laing was also part of
 24 the original group that was asked, but I think
 25 that that was more in relation to having an

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1 oncologist there. I also know that we have
 2 three ethicists that we use, Natalie Bandrauk,
 3 Fern Brunger and Daryl Pullman, and so the
 4 attempt would have been to have an ethicist,
 5 whichever was available at the time when the
 6 rest were available.
 7 CHAYTOR, Q.C.:
 8 Q. Not so much an individual, but is there any
 9 other group, and I've asked you already about
 10 any representative of families or patient
 11 perspective, it doesn't have to be the actual
 12 families involved, but a patient perspective,
 13 and no thought was given to that, as far as
 14 you know. So what about is there any other
 15 group there that you would have thought would
 16 have been represented, who are not amongst
 17 those in attendance?
 18 MS. JONES:
 19 A. Not at this level. You might be wondering
 20 whether administration, but we really don't
 21 get involved in or sit in on the consults. We
 22 take what comes from the consults.
 23 CHAYTOR, Q.C.:
 24 Q. And I think it came up in my earlier meeting
 25 with you, and it was you had given some

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1 thought with-- mentioned the communications
 2 personnel.
 3 MS. JONES:
 4 A. Right.
 5 CHAYTOR, Q.C.:
 6 Q. Would you have expected someone from your
 7 communications personnel to be in attendance?
 8 MS. JONES:
 9 A. Yeah, now that you mention that, I did mention
 10 that earlier and it could very well be there
 11 as well.
 12 CHAYTOR, Q.C.:
 13 Q. Do the communications people normally attend
 14 or is it only when there's an issue around
 15 communication?
 16 MS. JONES:
 17 A. Wouldn't normally attend.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, but if it's an issue around
 20 communications?
 21 MS. JONES:
 22 A. Most of these issues would end up being
 23 patient specific issues, so communication, you
 24 know, most of the ethical issues that we would
 25 look at would be in that realm. It's only on

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1 the administrative side where we might be
 2 looking at gambling or those kinds of things,
 3 or food choices, where we might have a
 4 perspective of how do you get information out
 5 at the end of the day, but communications
 6 would be brought in after the fact.
 7 CHAYTOR, Q.C.:
 8 Q. And if part of the deliberation would be
 9 whether or not to disclose to the broader
 10 community, would communications people usually
 11 be involved?
 12 MS. JONES:
 13 A. I don't know of any other ethics consult that
 14 we would have had that would have maybe had
 15 that element to it. So it would not have been
 16 in the natural thought process.
 17 CHAYTOR, Q.C.:
 18 Q. And so that's something that occurred to you
 19 after the fact?
 20 MS. JONES:
 21 A. After the fact, not as I read it.
 22 CHAYTOR, Q.C.:
 23 Q. And when we look at the people who were
 24 involved, other than of course Dr. Natalie
 25 Bandrauk, is it, Bandrauk?

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1 MS. JONES:
 2 A. Yes, Bandrauk.
 3 CHAYTOR, Q.C.:
 4 Q. And Rick Singleton, other than those two
 5 people, would any of the other people involved
 6 in this consult, to your knowledge have had
 7 any training in ethical issues?
 8 MS. JONES:
 9 A. Possibly not, but I would--do believe that
 10 Heather Predham would have been involved in
 11 other consults. Other than that, other than
 12 in their basic training.
 13 CHAYTOR, Q.C.:
 14 Q. So does Heather Predham, the risk management
 15 or somebody from risk management sit in on all
 16 ethical consults?
 17 MS. JONES:
 18 A. No.
 19 CHAYTOR, Q.C.:
 20 Q. But she would have been involved prior?
 21 MS. JONES:
 22 A. Prior, on this particular issue.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and I understand that currently there is
 25 an ethics facilitator's course?

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1 MS. JONES:
 2 A. Yes, there is.
 3 CHAYTOR, Q.C.:
 4 Q. Is that offered through Eastern Health?
 5 MS. JONES:
 6 A. It's offered through Eastern Health, and we've
 7 also offered that to the other regional health
 8 authorities as well, when we have done the
 9 last course that we did.
 10 CHAYTOR, Q.C.:
 11 Q. Okay, and people attending that course, do
 12 they achieve a certification of some sort?
 13 MS. JONES:
 14 A. They--it's an in-house program, okay, but once
 15 they complete it, yes, we use them for
 16 facilitators inside of our organization.
 17 CHAYTOR, Q.C.:
 18 Q. Okay, and what does that mean then? Like how
 19 long is this course and what exactly does it
 20 equip a person to do at the end of the day?
 21 MS. JONES:
 22 A. I think you best ask Mr. Singleton, Dr.
 23 Singleton. It's been a while since I've
 24 looked at that course, but when we first
 25 developed it, it had facilitation skills. It

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1 had ethics, ethics background, and that and we
 2 offered it over a couple of days. In the last
 3 two years or so, we've offered an ethics
 4 course which happened over a period of time,
 5 throughout the entire province, and we did
 6 issue a certificate on that, and that would
 7 have been more than a two-day course. So most
 8 of the individuals who would have been working
 9 as facilitators would have had an interest in
 10 ethics. If they'd been a facilitator with us
 11 for a long period of time, would have had our
 12 original course that ran well over two days,
 13 and probably also have the ethics certificate
 14 course that we ran about two years ago, and we
 15 ran it for the entire province.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, so this is still within your
 18 responsibility, your realm of responsibility?
 19 MS. JONES:
 20 A. Yes, it is.
 21 CHAYTOR, Q.C.:
 22 Q. The ethics?
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. And so this is--is this something new in the
 2 past couple of years, that you've been doing
 3 the course?
 4 MS. JONES:
 5 A. The course, we've offered it once.
 6 CHAYTOR, Q.C.:
 7 Q. Okay.
 8 MS. JONES:
 9 A. So it is--because there was so much interest
 10 in the province, as well as inside of Eastern
 11 Health, old Health Care Corporation of St.
 12 John's, we moved forward with a course. We
 13 had been doing workshops or seminars, if you
 14 want to call it, three times a year on ethics
 15 issues. Using the workshops, we probably have
 16 a hundred plus individuals from inside of old
 17 Health Care Corporation that would come three
 18 times a year. We would work through some
 19 policy issues at those and we would be
 20 bringing forward current issues. So that is
 21 how we had operated ethics inside of the
 22 organization for a long time. So it would be
 23 policy work up. We would have papers that we
 24 would have reaction to inside of the ethics
 25 days and then current topics as we move

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1 forward.
 2 CHAYTOR, Q.C.:
 3 Q. Okay, and so the actual course itself, would
 4 though that enable the person to be a
 5 facilitator?
 6 MS. JONES:
 7 A. Would enable, yes, they would have to do the
 8 facilitator course.
 9 CHAYTOR, Q.C.:
 10 Q. Okay, and was that only offered to people who
 11 work for Eastern Health or was it the broader
 12 community?
 13 MS. JONES:
 14 A. The last time when we offered the full course,
 15 we followed up the full course with our own
 16 ethics facilitation and anybody who was in the
 17 course from across the province who wanted to
 18 continue on to do the skills for a
 19 facilitator, it was available to them.
 20 CHAYTOR, Q.C.:
 21 Q. When the organization went through an
 22 accreditation, just this past year, and when
 23 had it last been accredited? Was it 2004?
 24 MS. JONES:
 25 A. Different organizations would have been, but

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1 mainly in 2004, parts of our organization
 2 would have had accreditations before that, and
 3 they ended up having to have an interim
 4 accreditation, so we brought the organization
 5 along to have all parts of it in 2007.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, yes, because of course 2005, you became
 8 Eastern Health?
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. So there was a recommendation mentioned in the
 13 2007 that there had been follow up to address
 14 clinical ethical issues. So presumably it's a
 15 recommendation that came from the 2004. Are
 16 you aware of what that was? What was -
 17 MS. JONES:
 18 A. That one wouldn't have come from the old
 19 Health Care Corporation, I don't think. It
 20 may have come from some of the other legacy
 21 boards, particularly Carbonear or the Health
 22 and Community Services or whatever, because I
 23 don't remember the old Health Care Corporation
 24 having an ethics recommendation, but the other
 25 six legacy boards may very well have because

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1 they would not have had the level of work done
 2 in ethics that we had, because we were a
 3 bigger board and had those resources
 4 associated with it.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, so to your knowledge, there was no issue
 7 with any ethical clinical issues out of the
 8 Health Care Corporation?
 9 MS. JONES:
 10 A. No.
 11 CHAYTOR, Q.C.:
 12 Q. And you don't know what the issues may have
 13 been in the other legacy organizations?
 14 MS. JONES:
 15 A. In the other boards, it may very well have
 16 been structures or ethics education or
 17 consults. They would not have had access to
 18 the ethicist like we did, because we had a
 19 contract with Memorial.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, if we could go back then to this
 22 specific ethical consult, and we're looking
 23 here at 0481, page two.
 24 THE COMMISSIONER:
 25 Q. Exhibit 0481?

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1 CHAYTOR, Q.C.:
 2 Q. Exhibit 0481, yes, page two. Ms. Jones, did
 3 you receive a copy of this report?
 4 MS. JONES:
 5 A. Dr. Singleton sent me the copy of the report
 6 once it was completed. That ultimately went
 7 for filing in our system, just to let me know
 8 that in fact it had been completed.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. So did you read the report when you
 11 received it?
 12 MS. JONES:
 13 A. I did.
 14 CHAYTOR, Q.C.:
 15 Q. You did, okay, and did you ask that any follow
 16 up take place?
 17 MS. JONES:
 18 A. Only that communication be--if you scroll
 19 down, I think that there was some reference to
 20 communication.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. That may be on a different document.
 23 So I'm sorry, you asked that it be forwarded
 24 to communications, is that right?
 25 MS. JONES:

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1 A. That Rick Singleton would have, in fact, made
 2 sure that communications was aware of it,
 3 because it says a press release prepared as a
 4 matter of--so being that they were not part
 5 of, that they would need to be aware that this
 6 consult had taken place and that they would
 7 have needed to be in the loop.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, so you contacted who to make sure that
 10 happened?
 11 MS. JONES:
 12 A. Only Rick.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, so you contacted Rick to make sure
 15 communications people were aware that one of
 16 the recommendations concerned a press release?
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. Okay. Did you have any concerns with the
 21 content of the report or did you agree with
 22 the content?
 23 MS. JONES:
 24 A. There was nothing that struck me at the time
 25 that I would not have agreed with.

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1 CHAYTOR, Q.C.:

2 Q. And if we come down to the second paragraph,

3 it starts with "the problem with the results

4 was rooted in the test procedures used in the

5 time period from 1997 to 2005." And then it

6 goes on with, "In 2005 samples known to have

7 been processed for this batch of patients were

8 forwarded to Mount Sinai in Toronto for

9 retesting at their lab." And "In the batch

10 forwarded to Mount Sinai there were 101

11 samples from deceased patients. 19 of the

12 retested samples produced results that may

13 have resulted in a different care plan and

14 follow-up than that implemented based on the

15 original test results." Then "The important

16 facts to the history and understand of this

17 case include the following: There were no

18 mistakes or technical errors at the root of

19 this problem." Who determined the facts,

20 first of all, that would be relied upon, is

21 that something that's generated at the time

22 that the group is brought together?

23 MS. JONES:

24 A. At the time the group is brought together.

25 CHAYTOR, Q.C.:

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1 Q. So the important facts to the history and to

2 understand the case, that would have been

3 brought forward by the people who you say were

4 knowledgeable about the issue?

5 MS. JONES:

6 A. Knowledgeable at the table.

7 CHAYTOR, Q.C.:

8 Q. So those in attendance at the--in the room?

9 MS. JONES:

10 A. That's right.

11 CHAYTOR, Q.C.:

12 Q. Okay.

13 MS. JONES:

14 A. And there may have been, and you'll have to

15 ask Dr. Singleton, whether in the prep work

16 for this there was other information that he

17 had gained to be brought forward to the table,

18 but I would not have thought that because the

19 people who were at the table would have been

20 able to provide the background to this

21 particular issue.

22 CHAYTOR, Q.C.:

23 Q. Okay. And when you read the report, did that

24 raise any concern to you as to whether or not

25 that, in fact, was a correct statement, "There

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1 were no mistakes or technical errors at the

2 root of this problem." and whether or not that

3 might have any impact on the outcome of the

4 ethical consult?

5 MS. JONES:

6 A. As you have heard me say earlier on this

7 morning, what was in the actual reviews that

8 were done, peer reviews, that the information,

9 we knew that they were moving forward on

10 recommendations, but this would not have

11 raised a flag to say I knew something

12 different that had never been said that there

13 were technical errors.

14 CHAYTOR, Q.C.:

15 Q. Um-hm. Your understanding, and again, this is

16 in May, 2006?

17 MS. JONES:

18 A. Six.

19 CHAYTOR, Q.C.:

20 Q. And your understanding at that point in time,

21 as much as you've heard had been concerning

22 machinery and the fixation issue?

23 MS. JONES:

24 A. And the fixation issue and that we have

25 policies and procedures, you know, our

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1 documentation was we were moving forward with

2 documentation and solidifying that.

3 CHAYTOR, Q.C.:

4 Q. And "No mistakes or technical errors," do you

5 read that as being broader than a technical

6 error?

7 MS. JONES:

8 A. In the context of how the lab works, I don't

9 know how you would read that, "mistakes or

10 technical errors." I would have just thought

11 they were moving forward with issues that had

12 been brought forward, whether it was a

13 technical error or not, I don't know.

14 CHAYTOR, Q.C.:

15 Q. Okay. "The main ethical issue" then, the next

16 paragraph.

17 MS. JONES:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. "The main ethical issue in this case pertains

21 to disclosure."

22 MS. JONES:

23 A. Um.

24 CHAYTOR, Q.C.:

25 Q. "There are several considerations regarding

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1 the duty to disclose, the right of families to
 2 be informed of results from the retesting in
 3 Mount Sinai and who should manage the
 4 disclosure process. The obligation to
 5 disclose information to families is based from
 6 an ethics perspective on the negative right of
 7 families to information about the deceased. A
 8 negative right respects the right of
 9 individuals or families to access
 10 information." So it's a right to access the
 11 information.
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. "But does not oblige anyone to make direct
 16 contact with individuals or families to
 17 provide the information. The obligation to
 18 inform is different in this situation than if
 19 situations where a mistake had been made."
 20 MS. JONES:
 21 A. Um.
 22 CHAYTOR, Q.C.:
 23 Q. "Where the information would make a difference
 24 or potential difference in the care plan or
 25 interventions of the patient."

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. And when you read that, did anything
 5 there jump out or cause you any concern or
 6 give you any further clarity as to what the
 7 word "mistake" may mean?
 8 MS. JONES:
 9 A. No. And I had to go back at least maybe once
 10 or twice to get this concept of negative
 11 right.
 12 CHAYTOR, Q.C.:
 13 Q. Yes.
 14 MS. JONES:
 15 A. It would not have been a concept that--we--
 16 positive right, negative right didn't mean
 17 anything to me. But as I read it more, I did
 18 understand from my perspective what it meant.
 19 CHAYTOR, Q.C.:
 20 Q. Okay. So being--what do you understand then
 21 that to mean?
 22 MS. JONES:
 23 A. Well, if you go on to the second part of that,
 24 "A negative right respects the rights of
 25 individuals or families to access

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1 information." So that's come forward and
 2 looking for information. "But does not oblige
 3 the" Eastern Health at the time, "to direct
 4 contact with individuals or patients to
 5 provide information. The obligation is to
 6 inform, to inform is different if this
 7 situation were a mistake." And at this point
 8 in time you read earlier on where it says, "No
 9 technical errors, no mistakes."
 10 CHAYTOR, Q.C.:
 11 Q. Right.
 12 MS. JONES:
 13 A. So if you read the two of them in concert,
 14 that would be where I would have read that.
 15 CHAYTOR, Q.C.:
 16 Q. So would be a different situation if it were
 17 based on a fact situation where a mistake had
 18 been made?
 19 MS. JONES:
 20 A. That's right. And we have lots of instance
 21 where if, in fact, there is a death and
 22 there's a directly attributable to something
 23 that's happened, we deal with families all the
 24 time on that.
 25 CHAYTOR, Q.C.:

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1 Q. So if a mistake had caused or contributed -
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. - or a mistake had been involved the care of
 6 the patient, so for example, if a mistake
 7 caused or contributed to the particular care
 8 that a patient received and that patient went
 9 on to die, regardless if the mistake was
 10 related to the death, would there be
 11 disclosure to the family that there had been a
 12 mistake made in the care or treatment plan?
 13 MS. JONES:
 14 A. The only ones that I would be aware of is if
 15 there has been a death and it's within a very
 16 limited time frame, right.
 17 CHAYTOR, Q.C.:
 18 Q. So if there's a death -
 19 MS. JONES:
 20 A. With an associated cause.
 21 CHAYTOR, Q.C.:
 22 Q. Or contributing factor, based on the treatment
 23 of the patient, then there would be -
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. - disclosure to the family?

3 MS. JONES:

4 A. Yeah.

5 CHAYTOR, Q.C.:

6 Q. But if there's not necessarily causal link or

7 unknown if there's a causal link, is there

8 still an obligation to disclose?

9 MS. JONES:

10 A. I'm not sure we come across that very often,

11 because usually what happens is that we

12 have a situation in front of us, we're able to

13 develop a causal relationship. This

14 particular situation we had clients and

15 families that are in excess of ten years, so

16 I'm not sure. And we already have the

17 instance here about technical errors or

18 mistakes and already been referenced in the

19 discussion that happened at this case.

20 CHAYTOR, Q.C.:

21 Q. Yes, so I guess that issue didn't get

22 addressed in this consult?

23 MS. JONES:

24 A. That's right.

25 CHAYTOR, Q.C.:

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1 Q. Yes. Do you currently have the policy which

2 addresses disclosure to the families of

3 deceased patients?

4 MS. JONES:

5 A. No. Our disclosure policy continues to be the

6 disclosure, one of individual patients, not

7 public disclosure and not for mass, mass

8 disclosures.

9 CHAYTOR, Q.C.:

10 Q. Now if we continue on then, it says, and I

11 guess this is where the lawyer in the room

12 comes into the picture, "While legally no one

13 has the right to a deceased person's health

14 record or other health information, in the

15 context of the core values of Eastern Health

16 and in the spirit of goodwill, it is

17 appropriate that Eastern Health take

18 reasonable steps to inform the community that

19 this problem has occurred and that the

20 information is available."

21 MS. JONES:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. What is the policy of Eastern Health for

25 provision of information to the family or

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1 estate representatives of a deceased person?

2 So if next of kin come forward and want

3 information on their family, what's Eastern

4 Health's policy?

5 MS. JONES:

6 A. If next of kin come forward, we will provide

7 them, providing we can determine that it is

8 the next of kin.

9 CHAYTOR, Q.C.:

10 Q. Right. So I take it if they're able to

11 appropriately identify themselves -

12 MS. JONES:

13 A. Yes.

14 CHAYTOR, Q.C.:

15 Q. - and they come forward with any questions

16 regarding their relative, they would be

17 provided with the information?

18 MS. JONES:

19 A. Yes. Chart and physician access, depending on

20 what the issue is.

21 CHAYTOR, Q.C.:

22 Q. Right, okay. So regardless of what may be

23 said here, whether or not there's a legal

24 right to that information or not, it is the

25 policy of Eastern Health to provide that

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1 information?

2 MS. JONES:

3 A. It's the practice of Eastern Health. We don't

4 have a policy on that, it is the practice.

5 CHAYTOR, Q.C.:

6 Q. And that's been, I would take it, your

7 practice for quite some time?

8 MS. JONES:

9 A. For quite some time.

10 CHAYTOR, Q.C.:

11 Q. And what are the core values of Eastern

12 Health, is that a document, is that written

13 somewhere?

14 MS. JONES:

15 A. They would be the values on which things such

16 as respect, integrity, excellence, those kinds

17 of things, so they would be listed out. Those

18 were adopted in 2005 and we just reaffirmed

19 and changed the nature of some of them in the

20 fall through the board strategic planning

21 process, so inherent in those values are all

22 of the previous values, they may have

23 different words around them. And we've also

24 moved to have behaviours associated with the

25 values, what we would expect for staff under

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1 particular values.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. I'm sorry, what did you say they are?
 4 MS. JONES:
 5 A. I can't name them all off, but it would be
 6 respect, integrity, excellence, growth was in
 7 the original ones because initially they came
 8 out of the Department of Health's Strategic
 9 Planning document, that was early in 2005. We
 10 go through a process, an internal process
 11 where we consult with staff and talk about
 12 values and talk about what the organization
 13 wants, what the organization should be. And
 14 so we've just gone through an entire process
 15 in the spring of this year to look at values,
 16 to reaffirm values and then to bring them into
 17 our strategic planning documents as well as
 18 then those core values become part of the way
 19 that the organization lines up and is
 20 evaluated against. So we put them in our
 21 performance appraisals, we put them in our
 22 staff evaluations and those kinds of things.
 23 So this is what we expect our staff to act
 24 like.
 25 CHAYTOR, Q.C.:

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1 Q. Would accountability and transparency be part
 2 of the core values?
 3 MS. JONES:
 4 A. Yes, it is, yes.
 5 CHAYTOR, Q.C.:
 6 Q. Would be -
 7 MS. JONES:
 8 A. Incorporated in. It may not be actually
 9 called accountability and transparency. But
 10 connectedness is a new word that we've used
 11 this time to connect with the public and the
 12 community.
 13 CHAYTOR, Q.C.:
 14 Q. What does that mean?
 15 MS. JONES:
 16 A. To be open, to be transparent and out there
 17 communicating.
 18 CHAYTOR, Q.C.:
 19 Q. And are those new--the open, transparent, the
 20 connectedness to the community, is that part
 21 of the revisions that were just made this
 22 fall?
 23 MS. JONES:
 24 A. That's part of the revisions, yes.
 25 CHAYTOR, Q.C.:

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1 Q. That's part of the revisions.
 2 THE COMMISSIONER:
 3 Q. Openness, connectedness is openness,
 4 transparency?
 5 MS. JONES:
 6 A. We can get you, actually, a copy of that if
 7 you -
 8 THE COMMISSIONER:
 9 Q. Isn't that on your web site?
 10 MS. JONES:
 11 A. It is on the web site.
 12 THE COMMISSIONER:
 13 Q. I thought it was.
 14 MS. JONES:
 15 A. Right. The new word we use is "connectedness"
 16 because that makes more, you know, it made
 17 more sense when you read what it is that we're
 18 trying to do, link with the community and be
 19 open and transparent and those kinds of
 20 things, we've used that word.
 21 CHAYTOR, Q.C.:
 22 Q. Okay.
 23 THE COMMISSIONER:
 24 Q. While we're on the subject.
 25 MS. JONES:

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1 A. Yes.
 2 THE COMMISSIONER:
 3 Q. I have a great deal of difficulty with the
 4 word "transparency." Every person who speaks
 5 it seems to think it's of a different thing.
 6 MS. JONES:
 7 A. Um-hm.
 8 THE COMMISSIONER:
 9 Q. So I'd really like your view as to what
 10 transparency means for Eastern Health.
 11 MS. JONES:
 12 A. It's been--we tie it with accountability.
 13 It's openness, responsiveness to questions or
 14 issues that come forward, and at the end of
 15 the day to the extent that we can, making that
 16 information available. So transparent in the
 17 way that we do our work, open to answering
 18 questions about how we do our work. And
 19 honesty is another word that's used in the
 20 behavioural side of that, as well, being
 21 honest with ourselves as we do our work and as
 22 we communicate.
 23 THE COMMISSIONER:
 24 Q. The word "transparency" coupled with
 25 "accountability" turns up in a piece of

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1 legislation, which is -
 2 MS. JONES:
 3 A. Yes.
 4 THE COMMISSIONER:
 5 Q. - relevant to your organization. In this
 6 context, though, does transparency mean
 7 something more than the legislation requires
 8 you to do?
 9 MS. JONES:
 10 A. Absolutely.
 11 THE COMMISSIONER:
 12 Q. Okay.
 13 MS. JONES:
 14 A. And it's in the way that we've talked about
 15 connectedness, and I think if you look at the
 16 document that we've actually worked with staff
 17 that talks about key behaviours and
 18 expectations, that is what we're out talking
 19 to staff about what we want to evaluate them
 20 on. They're really aspirational statements in
 21 that we expect everybody to work to achieve
 22 those kind of things.
 23 CHAYTOR, Q.C.:
 24 Q. And, I'm sorry, so what do you define as
 25 accountability?

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1 MS. JONES:
 2 A. It is being accountable to the government,
 3 okay, to our staff for the decisions and the
 4 actions that we make, and then to the public
 5 for the services and that that we deliver on.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. And accountability to the public in it
 8 being a publicly funded system?
 9 MS. JONES:
 10 A. Publicly funded system that we report to. We
 11 have annual meetings that report on the work
 12 that we do, the services that we provide.
 13 CHAYTOR, Q.C.:
 14 Q. Okay. And accountability then within, is
 15 there also internal accountability in
 16 envisioned -
 17 MS. JONES:
 18 A. Absolutely.
 19 CHAYTOR, Q.C.:
 20 Q. How does that work?
 21 MS. JONES:
 22 A. We talked earlier on about being if for your
 23 particular area and the mandate that you have,
 24 we talked about budget accountability, being
 25 responsible for identifying issues, bringing

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1 the issues forward, those kinds of things.
 2 And we expect staff to work to their best
 3 potential, given the resources and that and
 4 being accountable for the work that they
 5 actually do and delivering quality work.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. And how do you measure whether or not
 8 the staff and the people working within your
 9 institution have been accountable?
 10 MS. JONES:
 11 A. I think lots of it is in the service that they
 12 provide, okay, and in the--in providing it in
 13 a certain way and in a fashion. We look at
 14 the issues that come forward, either in
 15 complaints or compliments to see how they do,
 16 and in lots of ways we audit things to make
 17 sure that things are complete or are completed
 18 in a way that it's supposed to be. So that
 19 is, you have an accountability to do the job
 20 to the best of your ability with the tools
 21 that we've got and that we have provided you
 22 with.
 23 CHAYTOR, Q.C.:
 24 Q. And how is that reviewed with staff?
 25 MS. JONES:

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1 A. Performance appraisals and in direct feedback
 2 that we have with managers talking to staff in
 3 their work day and those kinds of things.
 4 CHAYTOR, Q.C.:
 5 Q. And is there also that kind of feedback or
 6 evaluation for management?
 7 MS. JONES:
 8 A. Yes, there is.
 9 CHAYTOR, Q.C.:
 10 Q. And I take it that's all the way up the chain?
 11 MS. JONES:
 12 A. Including the CEO.
 13 CHAYTOR, Q.C.:
 14 Q. Including the CEO and you would be accountable
 15 to the board?
 16 MS. JONES:
 17 A. To the board.
 18 CHAYTOR, Q.C.:
 19 Q. And the board chair would do your evaluation?
 20 MS. JONES:
 21 A. Yes. It actually is a committee of the board
 22 that does an evaluation of the CEO based upon
 23 a number of objectives that the board and the
 24 government has set for the position over the
 25 year and so that is a report that goes to the

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1 board chair and then there is a discussion
 2 with the board chair and the CEO.
 3 CHAYTOR, Q.C.:
 4 Q. And what about the physicians with privileges
 5 within your organization?
 6 MS. JONES:
 7 A. We are getting much more aggressive with a
 8 discussion between the clinical chiefs or the
 9 department heads with physicians. We have
 10 profiles of physicians in terms of their work
 11 profile, the kind of work that they do. We do
 12 have performance appraisals in the sense of
 13 physician performance appraisals, probably not
 14 done as regularly as we would like them to be,
 15 but there is definitely a move, there is a
 16 process, there are forms and that there is
 17 discussion that happens with the clinical
 18 chief or the division chair with the members
 19 of the department.
 20 CHAYTOR, Q.C.:
 21 Q. Okay, and you say that you're getting more
 22 aggressive along those lines, so is there a
 23 system in place and has been in place for
 24 awhile but hasn't necessarily been followed
 25 through on a regular basis or has there been

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1 no -
 2 MS. JONES:
 3 A. There's a credentialing part for medical
 4 staff, so every time that an individual comes
 5 forward for credentialing, there is a formal
 6 process around that credentialing, but we are
 7 wanting to make it more of a yearly thing,
 8 verses when your credentials are coming up for
 9 review and every three years or five years,
 10 depending upon what organization you had been
 11 in before.
 12 CHAYTOR, Q.C.:
 13 Q. And when was that initiated, that you would
 14 have -
 15 MS. JONES:
 16 A. Dr. Howell has got that well underway, but we
 17 had in Dr. Williams' time also been moving
 18 forward with documentation. It's not that the
 19 stuff is not done, it's not that they don't do
 20 audits and rounds, but it's the documentation
 21 part of the review performance that we're
 22 talking about.
 23 CHAYTOR, Q.C.:
 24 Q. And has there been any reluctance expressed
 25 towards that?

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1 MS. JONES:
 2 A. I can't say there really is, lots of times
 3 it's a time constraint to be able to get it
 4 done, but not the reluctance.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. And in terms of then moving it forward,
 7 Dr. Howell has responsibility for that.
 8 MS. JONES:
 9 A. Yes, that's on the physician side.
 10 CHAYTOR, Q.C.:
 11 Q. And does that also have to do with the
 12 decisions around employees of Eastern Health?
 13 MS. JONES:
 14 A. Credential physicians either way, employees or
 15 -
 16 CHAYTOR, Q.C.:
 17 Q. They're all put through the same?
 18 MS. JONES:
 19 A. All put through the same.
 20 CHAYTOR, Q.C.:
 21 Q. If we could just go back then to 0481, it
 22 says, "Contact with families ought to"--and I
 23 take it the word "be" is missing--"ought to be
 24 managed mainly by the risk manager with the
 25 assistance of competent staff and the

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1 Corporate Communications Department. The
 2 ethics consultation had several
 3 recommendations in this regard." So why would
 4 the contact with families be managed by the
 5 risk manager?
 6 MS. JONES:
 7 A. And I think the risk manager here in this
 8 nature of what is said here is the Quality
 9 Department because many of the contacts that
 10 were made with families involved in the ER/PR
 11 where there was no change in result was made
 12 by what we call quality facilitators in our
 13 organization or in the other regional health
 14 authorities were experienced nurses, so that
 15 would have been where the calls would have
 16 come from.
 17 CHAYTOR, Q.C.:
 18 Q. Okay, so obviously the plan is going to be
 19 that it is going to be managed by the risk
 20 manager with the assistance of competent
 21 staff.
 22 MS. JONES:
 23 A. Uh-hm.
 24 CHAYTOR, Q.C.:
 25 Q. And the Corporate Communications Department.

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And the Corporate Communications Department
 5 being, I guess, to look at the first item
 6 being a press release prepared.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. As this matter is being resolved, ought to
 11 mention that information pertaining to
 12 deceased patients may be available by
 13 contacting the appropriately designated
 14 officer number.
 15 MS. JONES:
 16 A. That's right.
 17 CHAYTOR, Q.C.:
 18 Q. Efforts should be made secondly to ensure
 19 information about the retested samples be
 20 presented by an individual competent to
 21 explain the matters to a family member.
 22 MS. JONES:
 23 A. Right.
 24 CHAYTOR, Q.C.:
 25 Q. And thirdly, families of deceased patients

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1 whose samples have not been retested request
 2 the same information, then it should be
 3 explained that the sample has not yet been
 4 retested, but it would be on request.
 5 MS. JONES:
 6 A. Uh-hm.
 7 CHAYTOR, Q.C.:
 8 Q. So the plan at this point in time was not to
 9 retest all the deceased.
 10 MS. JONES:
 11 A. That's right.
 12 CHAYTOR, Q.C.:
 13 Q. Only if requested by the family.
 14 MS. JONES:
 15 A. Yeah, and you have to understand, as you've
 16 already gone through what the nature of this
 17 request for the ethics counsel was, we had
 18 results, yeah.
 19 CHAYTOR, Q.C.:
 20 Q. And then did this go ahead, like was there a
 21 press release issued at this point in time?
 22 MS. JONES:
 23 A. There wasn't that I know of at this point in
 24 time and then later on there was a decision to
 25 retest all of the deceased and then in

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1 February of this year, there was the public
 2 release. There was a follow up in the papers
 3 with the local media, there was follow up with
 4 the "Globe and Mail" and then there were
 5 public service announcements.
 6 CHAYTOR, Q.C.:
 7 Q. So it's sometime later, it's February 2008
 8 that that actually happens.
 9 MS. JONES:
 10 A. That's right.
 11 CHAYTOR, Q.C.:
 12 Q. After all the deceased samples have been
 13 retested.
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. Do you know why at this point in time the set
 18 out plan was not followed?
 19 MS. JONES:
 20 A. I can't tell you why that was not actioned at
 21 that time.
 22 CHAYTOR, Q.C.:
 23 Q. You haven't had any discussions around that?
 24 MS. JONES:
 25 A. No.

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1 CHAYTOR, Q.C.:
 2 Q. And it didn't come up at the executive
 3 management level?
 4 MS. JONES:
 5 A. No, it didn't.
 6 CHAYTOR, Q.C.:
 7 Q. And being the person who would be responsible
 8 for ethics and pastoral care, any follow up on
 9 that or speaking to Dr. Williams to find out
 10 why you haven't had that discussion?
 11 MS. JONES:
 12 A. No, and this, this is a consult and what we do
 13 with consults and ethics as they go back to
 14 the orderer of the consult or the requester of
 15 the consult, so they are a set of
 16 recommendations and whether in fact those are
 17 actioned or not, really depends upon--it is
 18 literally a consult. The individual that
 19 requested it would then action it to the
 20 extent that they were--wished to action it.
 21 CHAYTOR, Q.C.:
 22 Q. So this went back to Dr. Williams.
 23 MS. JONES:
 24 A. Yes, it did.
 25 CHAYTOR, Q.C.:

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1 Q. And he was the person who initiated it.
 2 MS. JONES:
 3 A. Yes.
 4 CHAYTOR, Q.C.:
 5 Q. So why at that point in time it wasn't acted
 6 upon, he'd be the person to give that answer.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. And you haven't had any discussions with him
 11 on that?
 12 MS. JONES:
 13 A. No.
 14 CHAYTOR, Q.C.:
 15 Q. If we could have P-0778 please? Now, Ms.
 16 Jones, this document is e-mails from Rick
 17 Singleton to a number of people, including
 18 yourself.
 19 MS. JONES:
 20 A. Uh-hm.
 21 CHAYTOR, Q.C.:
 22 Q. And Dr. Williams, Heather Predham, Kara Laing,
 23 Dr. Denic and it's dated May 19th, 2006 and
 24 you can see this is an e-mail where down at
 25 the bottom, the earlier one is May 19th, 2006

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1 and Rick Singleton is writing to the same
 2 group of people, including Daryl Pullman at
 3 that point in time.
 4 MS. JONES:
 5 A. Uh-hm.
 6 CHAYTOR, Q.C.:
 7 Q. And it's regarding the ethics consult and he
 8 indicates he's been asked to organize an
 9 ethics consult to discuss the ethical issues
 10 regarding disclosure of information, ER/PR
 11 results from Mount Sinai to families of the
 12 deceased patients. When organizing an ethics
 13 consult, we need to get the right people, the
 14 right mix of people to have a discussion and
 15 generate reasonable recommendations." And at
 16 this point in time he's looking at Dr. Pullman
 17 as an ethicist, Dr. Cook and Dr. Denic from
 18 the lab, Dr. Laing from the cancer program.
 19 MS. JONES:
 20 A. Yes, uh-hm.
 21 CHAYTOR, Q.C.:
 22 Q. And then you'll see at the top there's a
 23 response from May 19th, 2006 again, just about
 24 a half an hour or so later where he's
 25 indicating that May 29th is not possible and

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1 they're now looking at dates in June, the
 2 13th, the 16th.
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. If we could have then, please and certainly at
 7 this point in time and you'll see down here
 8 you're copied on this e-mail.
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. But you're also sent it directly, so you
 13 probably got it twice. Certainly in looking
 14 at the mix of people to have around the table,
 15 there's no indication on May 19th by Dr.
 16 Singleton of a necessity of having a lawyer
 17 present?
 18 MS. JONES:
 19 A. No, not at that time, these are internal
 20 people. He may very well have had some other
 21 discussion, but you'll have to ask him.
 22 CHAYTOR, Q.C.:
 23 Q. Well Dr. Pullman, is he internal?
 24 MS. JONES:
 25 A. Yes, he is, he is an ethicist at Memorial and

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1 we access him through our meditec system.
 2 CHAYTOR, Q.C.:
 3 Q. So that's considered internal.
 4 MS. JONES:
 5 A. He's considered internal.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and so do you know how it came up that,
 8 whose idea it was to include a lawyer on the
 9 panel?
 10 MS. JONES:
 11 A. I have no idea.
 12 CHAYTOR, Q.C.:
 13 Q. If we could look then at 0779? And this,
 14 again, is a continuation of the e-mail
 15 exchange and this is just Dr. Laing gets back
 16 to say that she's going to be away from June
 17 13th to the 20th.
 18 MS. JONES:
 19 A. Uh-hm.
 20 CHAYTOR, Q.C.:
 21 Q. And she's replied fairly promptly on May 19th,
 22 same date.
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. And 0780 please? And this is an e-mail from
 2 Mr. Singleton and this one is dated June 9th,
 3 2006?
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. Looks to be the same group of people,
 8 including yourself and Daryl Pullman and the
 9 same physicians and there's a F. Brunger.
 10 MS. JONES:
 11 A. That's Fern Brunger who is an ethicist and
 12 Natalie Bandrauk.
 13 CHAYTOR, Q.C.:
 14 Q. And Dr. McCarthy is included in there.
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And he's indicating that "we will have to
 19 again reschedule our meeting to discuss the
 20 disclosure of information regarding deceased
 21 patients. We have had difficulty getting a
 22 time with the lawyer who has been handling the
 23 case. He's in court almost every day this
 24 month." And so they're looking to reschedule
 25 to June 19th and "Mr. Dan Boone, the lawyer,

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1 will join us a bit late." So the new time is
 2 then set for June 19th, 5:00 p.m.
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. And you would have received that e-mail?
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. But again you don't know what happened in
 11 between and who suggested the lawyer?
 12 MS. JONES:
 13 A. And I know that Rick would have kept me in
 14 because I had called him and said Dr. Williams
 15 wants this done, right.
 16 CHAYTOR, Q.C.:
 17 Q. Okay, and if we could go then, please, to
 18 0781? And this is again from Rick Singleton
 19 and it's to Bob Williams. You are not copied
 20 on this.
 21 MS. JONES:
 22 A. No.
 23 CHAYTOR, Q.C.:
 24 Q. And it advises "Yesterday we had an ethics
 25 consult on ER/PR. Very good discussion and

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1 outcome. I will forward the summary later.
 2 In the meantime, there's an issue that came
 3 up. An issue came up that I should give you a
 4 heads up, I want to give you a heads up on.
 5 Dr. Denic had a document or a report with him
 6 from an external reviewer of the lab
 7 processes, et cetera here. He read from it
 8 and mentioned that he would use the report as
 9 part of information he was sharing with
 10 others. It seems the reporter opinion had
 11 been done for Dan Boone and he did not want
 12 the information shared, at this time it is
 13 privileged. Dr. Denic understood from you
 14 that he was not to copy it, but Dan seemed to
 15 be a bit concerned that it was being quoted,
 16 the expert being referred to. Dan's concern
 17 seems to be about the privilege status of the
 18 report which he may need in proceeding later
 19 on. Anyway, just thought I wanted to let you
 20 know there was a bit of fuss about it." Did
 21 anyone discuss that with you, that this issue
 22 came up?
 23 MS. JONES:
 24 A. No.
 25 CHAYTOR, Q.C.:

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1 Q. So you weren't aware of that.
 2 MS. JONES:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. If I could just go back please, and this
 6 indicates that the ethics consult took place
 7 yesterday, so that being June 19th, I would
 8 take it, the day before.
 9 MS. JONES:
 10 A. 19th, yes.
 11 CHAYTOR, Q.C.:
 12 Q. And if we could just go back then to the
 13 exhibit P-0481 please? This is dated May
 14 twenty-ninth, two thousand--and it looked like
 15 there had been a seven there and it's changed
 16 to a six?
 17 MS. JONES:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. Do you have any idea why that would be?
 21 MS. JONES:
 22 A. No.
 23 CHAYTOR, Q.C.:
 24 Q. And obviously this would predate if the
 25 consult didn't take place until June 19th,

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1 2006, the report couldn't have been generated
 2 May 29th, 2006?
 3 MS. JONES:
 4 A. No.
 5 CHAYTOR, Q.C.:
 6 Q. You have no idea?
 7 MS. JONES:
 8 A. I have no idea.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. If we could have then P-0782? And here
 11 we have what appears to be the same document.
 12 MS. JONES:
 13 A. To be the same letter. Yeah.
 14 CHAYTOR, Q.C.:
 15 Q. Dated June 20th, 2006.
 16 MS. JONES:
 17 A. Uh-hm.
 18 CHAYTOR, Q.C.:
 19 Q. And over here in the corner we have letterhead
 20 from General Hospital and if you scroll down
 21 through it and I don't expect you to take the
 22 time to do it, but I can tell you that it
 23 appears to be the same document.
 24 MS. JONES:
 25 A. Same document, yes.

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1 CHAYTOR, Q.C.:
 2 Q. But for the date and but for the letterhead in
 3 the top right-hand corner.
 4 MS. JONES:
 5 A. Uh-hm.
 6 CHAYTOR, Q.C.:
 7 Q. And again, I take it you can't shed any light
 8 on that?
 9 MS. JONES:
 10 A. No.
 11 CHAYTOR, Q.C.:
 12 Q. If we could look at 0783 please? And this one
 13 appears to be the report that you would have
 14 received.
 15 MS. JONES:
 16 A. Uh-hm.
 17 CHAYTOR, Q.C.:
 18 Q. And it's sent June 22nd, 2006 from Mr.
 19 Singleton to yourself and to Dr. Williams.
 20 MS. JONES:
 21 A. Uh-hm.
 22 CHAYTOR, Q.C.:
 23 Q. "Re: ethics consult. Hi Bob, attached is a
 24 report from the ethics consult, re: ER/PR.
 25 Thanks, Rick."

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And if we look at this one, it's dated June
 5 23rd, 2006 -
 6 MS. JONES:
 7 A. And Bandrauk is corrected.
 8 CHAYTOR, Q.C.:
 9 Q. Bandrauk is scratched off and corrected,
 10 there's no letterhead in the top right corner
 11 and, but I would suggest to you that the
 12 content -
 13 MS. JONES:
 14 A. It's the same one.
 15 CHAYTOR, Q.C.:
 16 Q. I can't say I've read every single word, but
 17 the comparison I've made, it appears to be the
 18 same.
 19 MS. JONES:
 20 A. Yes, the same.
 21 CHAYTOR, Q.C.:
 22 Q. How many consults took place?
 23 MS. JONES:
 24 A. According to this, one.
 25 CHAYTOR, Q.C.:

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1 Q. And in terms of the dates and why the dates
 2 are different, you have no idea?
 3 MS. JONES:
 4 A. I have no idea.
 5 CHAYTOR, Q.C.:
 6 Q. So we'll ask the author of the report, I take
 7 it.
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. If we could have 0487, please, Registrar? And
 12 I'll have to give you a new page reference
 13 because I understand our page numbers have
 14 changed, but the document I'm looking for is
 15 dated 7th of June, 2006. For those of you who
 16 have the exhibits from earlier, your page
 17 references would have changed, but I think
 18 it's just because there was a lot of blank
 19 pages, there was a lot of redactions and to
 20 speed up the process, we got rid of the
 21 redacted pages. Okay, here we go, it's the
 22 June 7th, 2006 and this is minutes of
 23 executive management meeting held on that
 24 date.
 25 MS. JONES:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. And again, Mr. Tilley is the chair, you are in
 4 attendance, as is Mr. Williams and Ms. Bonnell
 5 is not here on this date.
 6 MS. JONES:
 7 A. Okay.
 8 CHAYTOR, Q.C.:
 9 Q. I just want to take you to page 9 of the
 10 document and this is indicated to be
 11 guidelines for external briefing
 12 note/confidentiality. "For clarification
 13 purposes, Louise Jones advised the guidelines
 14 for external briefing notes should be defined.
 15 An ethics consultation on briefing notes and
 16 the content of information was requested and
 17 placed on hold. Forwarding such a document
 18 outside the organization has serious
 19 confidentiality issues. It was also noted
 20 that briefing notes to the minister that go to
 21 cabinet are protected. However, briefing
 22 notes sent directly to the minister are not.
 23 All documents forwarded to the department must
 24 have confidential watermark. Any documents
 25 forwarded externally must go through the

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1 director level first prior to release and in
 2 some cases, where necessary, through the
 3 executive". Now, Ms. Jones, can you tell us
 4 what was that all about?
 5 MS. JONES:
 6 A. That particular issue was a request that came
 7 down into the organization into our mental
 8 health program looking for information on an
 9 individual client. And we had a physician in
 10 our mental health program who was very
 11 distraught about individual patient
 12 information going to the Department of Health
 13 and was questioning why, in fact, the
 14 department would need information on an
 15 individual patient. We had had discussions,
 16 an ethics consult on that particular issue and
 17 this is the result of that. So, it really
 18 revolved around requests inside the
 19 organization for information that was on
 20 specific patients. And there was a real
 21 question mark on whether, in fact, that should
 22 be released to the department.
 23 CHAYTOR, Q.C.:
 24 Q. And who was asking for an ethics consultation
 25 on briefing notes and the content of

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1 information? Who was asking for such consult?
 2 MS. JONES:
 3 A. Actually, it would have been Dr. Kevin Hogan,
 4 who was -
 5 CHAYTOR, Q.C.:
 6 Q. Okay, so it was a physician actually asking
 7 for -
 8 MS. JONES:
 9 A. It was a physician, absolutely.
 10 CHAYTOR, Q.C.:
 11 Q. He was asking for consultation on briefing
 12 notes. So, I take it was a briefing note that
 13 was forwarded on a patient?
 14 MS. JONES:
 15 A. I'm not sure if it actually went, but there
 16 was definitely a briefing note prepared and
 17 I'm thinking that it went, yeah. Yes, it did
 18 go and he was aware of it after the fact. And
 19 therefore, he had acted for a question for
 20 discussion and for an ethics consult about
 21 patient information, individual patient
 22 information going outside of Eastern Health.
 23 CHAYTOR, Q.C.:
 24 Q. Okay. And did that consultation ever take
 25 place, a consultation on briefing notes and

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1 information that would go externally?
 2 MS. JONES:
 3 A. Yeah, and -
 4 CHAYTOR, Q.C.:
 5 Q. Has that taken place?
 6 MS. JONES:
 7 A. - that was -
 8 CHAYTOR, Q.C.:
 9 Q. It was put on hold as -
 10 MS. JONES:
 11 A. It was put on hold. I'm not really sure, I
 12 would have to go back and check on that to see
 13 where that actual (sic.) went. But there was,
 14 obviously, very much discussion with what kind
 15 of information would go outside of Eastern
 16 Health; if it was individual patient specific
 17 information then it probably was it. If it
 18 was a generic issue, then that would be very
 19 different that asking for individual patient
 20 information.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. Now, this issue coming up in June of
 23 '06 -
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. - when obviously there are briefing notes, at

3 this point in time pertaining to the ER/PR

4 issue -

5 MS. JONES:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. - or certainly assistance from Eastern Health

9 in drafting or providing information to the

10 department in their briefing notes, was this,

11 at all in the context of what was happening

12 with the ER/PR issue?

13 MS. JONES:

14 A. No, this was very specific to a mental health

15 case.

16 CHAYTOR, Q.C.:

17 Q. And this in terms of an ethics consultation on

18 briefing notes and the content of information.

19 It appears to be very broad and not peculiar

20 to any particular case.

21 MS. JONES:

22 A. Yes, that's right.

23 CHAYTOR, Q.C.:

24 Q. Has whether or not the ethics consultation

25 took place, which you're not sure of right

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1 now, has any policy come into being at Eastern

2 Health to deal with this issue?

3 MS. JONES:

4 A. No, no policy, okay, but just the discussion

5 around notes to go through and what is a level

6 of information that should be inside of those

7 notes.

8 CHAYTOR, Q.C.:

9 Q. So, that has taken place -

10 MS. JONES:

11 A. That has taken place.

12 CHAYTOR, Q.C.:

13 Q. - a discussion on that. And what's the

14 outcome of those discussions?

15 MS. JONES:

16 A. The outcome of those discussions is that on

17 generic issues, okay, you see this process

18 here where anything that is going outside of

19 Eastern Health really should be signed off on

20 by a director or an executive level, so that

21 we are aware of what's going to the department

22 and what is being requested. Sometimes these

23 are very technical and it may be the

24 department is calling into our finance

25 department looking for something and it really

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1 is basic information, but if there are issues

2 other than that, then what is it, what is the

3 kind of information that the department is

4 requesting and what level of detail does the

5 department need to move forward with whatever

6 it has to do on a particular issue.

7 CHAYTOR, Q.C.:

8 Q. So, the outcome is that someone at the

9 executive level now has to sign on information

10 provided.

11 MS. JONES:

12 A. If there's briefing notes, per se, okay.

13 CHAYTOR, Q.C.:

14 Q. Or information to be provided for briefing

15 notes?

16 MS. JONES:

17 A. Not all information to be provided. Even in

18 to this year we've had discussion with our

19 directors to say that the executive should be

20 aware of the information that's going to the

21 department and not necessarily having to sign

22 it off and the executive will determine

23 themselves if, in fact, it comes from them, or

24 it can come from a department or a manager

25 that might be making contact with.

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1 CHAYTOR, Q.C.:

2 Q. Okay. Now, this is coming up for discussion,

3 executive management in June of 2006.

4 MS. JONES:

5 A. Yes.

6 CHAYTOR, Q.C.:

7 Q. When was the decision made that the executive

8 would have to either be notified or sign off

9 on any information going -

10 MS. JONES:

11 A. We've been trying to do that for years, okay,

12 but there's been more requests inside of

13 Eastern Health for particular types of

14 information and it depends on maybe complaints

15 that the department has been getting and they

16 want background information. So, depending on

17 the personal contact or the link inside the

18 organization, there are calls coming inside of

19 Eastern Health every day.

20 CHAYTOR, Q.C.:

21 Q. So, what you're saying is that had been the

22 rule, in any event.

23 MS. JONES:

24 A. It had been increasing.

25 CHAYTOR, Q.C.:

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1 Q. And continues to be increased, is that it?
 2 MS. JONES:
 3 A. And we do try to keep a handle on what is
 4 going out of the organization.
 5 CHAYTOR, Q.C.:
 6 Q. And we know that, for example, Heather
 7 Predham, in this situation, provided
 8 information for briefing notes -
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. - or at least, one, that ends up August 2006
 13 in the Premier's office.
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. Would anyone have signed off on that?
 18 MS. JONES:
 19 A. I have no idea on that particular note.
 20 CHAYTOR, Q.C.:
 21 Q. But the rules should have been that someone at
 22 the executive level would either have to have
 23 been informed of it or signed off on it?
 24 MS. JONES:
 25 A. And that is depending--it was then up to the

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1 individual who was preparing that note or
 2 getting that information ready.
 3 CHAYTOR, Q.C.:
 4 Q. Yes. To make sure that he appropriate sign
 5 off or approval had been maintained.
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. And who, in Heather Predham's case, would that
 10 be? Who would be the executive person that
 11 she would have to -
 12 MS. JONES:
 13 A. In two thousand and -
 14 CHAYTOR, Q.C.:
 15 Q. In 2006.
 16 MS. JONES:
 17 A. - August 2006, I would expect because Heather
 18 reports to Pam Elliott at that time who is the
 19 program director, and at that time, Bob
 20 Williams had quality.
 21 CHAYTOR, Q.C.:
 22 Q. Okay. And if it were now in 2007, Pat Pilgrim
 23 -
 24 MS. JONES:
 25 A. Pat Pilgrim has quality now if it was coming

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1 from Heather Predham.
 2 CHAYTOR, Q.C.:
 3 Q. I guess that's since Dr. Howell took over, it
 4 would have been Pat Pilgrim.
 5 MS. JONES:
 6 A. In the fall of 2006.
 7 THE COMMISSIONER:
 8 Q. So, is the long and short of this that any
 9 briefing note that would haven been prepared
 10 by Heather Predham should have either been
 11 signed off on or at least the content having
 12 been run past -
 13 MS. JONES:
 14 A. It should, yeah, that would have been the long
 15 and short. I don't know, even in my role
 16 today, briefing notes to go elsewhere in the
 17 department, we usually provide information.
 18 In the ten months that I've been there, I've
 19 never signed off or I'm not aware--I'm not
 20 saying it didn't happen, of a briefing note.
 21 We always send information and we send it in
 22 the terms of a note, but having it called a
 23 briefing note, I'm not sure or Heather was
 24 providing information into a briefing note,
 25 I'm not sure what that August of 2006

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1 contained.
 2 CHAYTOR, Q.C.:
 3 Q. I take it, whether or not it's formally called
 4 a briefing note or it's documentation which
 5 ultimately might end up in a briefing note.
 6 MS. JONES:
 7 A. Yes.
 8 CHAYTOR, Q.C.:
 9 Q. You would expect that it would run by the
 10 appropriate member of the executive?
 11 MS. JONES:
 12 A. Somebody inside the organization.
 13 CHAYTOR, Q.C.:
 14 Q. The appropriate member of the executive.
 15 MS. JONES:
 16 A. On this particular issue--because it was so
 17 much an issue for Eastern Health, I would have
 18 expected lots of other kinds of things. I may
 19 not expect that an executive member on a less
 20 sensitive issue would have been involved in
 21 some of the discussions.
 22 CHAYTOR, Q.C.:
 23 Q. And if your employees name is going to end up
 24 being attached to the document, the briefing
 25 note that ends up the Premier's office, and

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1 your employees name is on that document as
 2 having been a drafter or contributor to the
 3 briefing note, you would expect before that -
 4 MS. JONES:
 5 A. Happened.
 6 CHAYTOR, Q.C.:
 7 Q. - happened, it would have been run by an
 8 executive member of your team.
 9 MS. JONES:
 10 A. Yes, somewhere along the executive team.
 11 CHAYTOR, Q.C.:
 12 Q. What does -
 13 MS. JONES:
 14 A. I'd also say, lots of time we provide
 15 information to the department and we don't
 16 know in what ultimate format that ends up
 17 being used inside the department. So, we may
 18 be asked for information, whether it's on
 19 costing information or whatever and we are a
 20 contributor of something that the department
 21 is doing. So, whether in fact, we know in the
 22 beginning that it becomes part of a briefing
 23 note that serves to go up the line to Cabinet
 24 or that it really--we do provide information.
 25 CHAYTOR, Q.C.:

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1 Q. Right, but the rule being though that the
 2 content of the information which could
 3 ultimately end up in a briefing note or any
 4 information, is there a magic to it being a
 5 briefing note as opposed to--if information is
 6 provided, what difference if it's a briefing
 7 note or not?
 8 MS. JONES:
 9 A. And I don't know how the department works on
 10 its briefing notes and it requests lots of
 11 information.
 12 CHAYTOR, Q.C.:
 13 Q. Yes.
 14 MS. JONES:
 15 A. And we do get requests that says central
 16 government is looking for information on A, B,
 17 C or D. Lots of times it's technical or lots
 18 of times it is, in fact, factual, costs of,
 19 how many of something we're doing. So,
 20 therefore, those are--they may be sensitive in
 21 terms of what the issue is that they're
 22 looking at on that particular day, but this
 23 particular issue, we would have probably been
 24 keeping the department informed on what was
 25 going on.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. So, I think then what you're saying is
 3 if someone picks up the phone from the
 4 department and has a question, whether it's on
 5 the budget or something financial, the person
 6 who can answer it there and then, you wouldn't
 7 expect that they'd have to run off and find
 8 the appropriate member of the executive to
 9 give that information -
 10 MS. JONES:
 11 A. And that's where we leave some discretion,
 12 okay.
 13 CHAYTOR, Q.C.:
 14 Q. Right, but if it's information that's clearly
 15 been articulated that it's being put together
 16 for a briefing note or if it's a -
 17 MS. JONES:
 18 A. That's a different story.
 19 CHAYTOR, Q.C.:
 20 Q. - document that's drafted or a portion of a
 21 document that's drafted with the intent that
 22 it go in a briefing note, those are the kinds
 23 of things that you would expect -
 24 MS. JONES:
 25 A. That we would absolutely want to understand

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1 that that's what they were being used for and
 2 they would have executives sign off.
 3 CHAYTOR, Q.C.:
 4 Q. They would, okay. The next paragraph says,
 5 "It was also noted that briefing notes to the
 6 minister that go to Cabinet are protected;
 7 however, briefing notes sent directly to the
 8 minister are not." Is this still you advising
 9 on this issue?
 10 MS. JONES:
 11 A. I wouldn't even know that.
 12 CHAYTOR, Q.C.:
 13 Q. So who is saying this? This is not you saying
 14 this?
 15 MS. JONES:
 16 A. Well for the clarification, it may very well
 17 be during the discussion that around executive
 18 table there would have been people who would
 19 have known that, but personally, I wouldn't
 20 have known that. I certainly know that the,
 21 what do you call it, the briefing notes to the
 22 minister that go to Cabinet are protected. We
 23 all would know that, all right, briefing notes
 24 that go from us to the minister, I would never
 25 have thought that they were protected.

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1 CHAYTOR, Q.C.:

2 Q. No, this says that they're not.

3 MS. JONES:

4 A. That's right.

5 CHAYTOR, Q.C.:

6 Q. Briefing notes sent directly to the minister

7 are not. So you understood that.

8 MS. JONES:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. You understood that briefing notes to the

12 minister that go to Cabinet are protected.

13 MS. JONES:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. You would have known that.

17 MS. JONES:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. However briefing notes sent directly to the

21 minister are not, so -

22 MS. JONES:

23 A. I understand that, but I don't know whether I

24 would have -

25 CHAYTOR, Q.C.:

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1 Q. That's your understanding.

2 MS. JONES:

3 A. I don't know whether I would have said that in

4 that context.

5 CHAYTOR, Q.C.:

6 Q. Why is this being said in this context?

7 MS. JONES:

8 A. I can't answer that question, only to say if

9 you go on, that all documents that we are

10 sending to, must have confidential watermark

11 and I can tell you that that doesn't happen on

12 a basis for information that is going, going

13 up.

14 CHAYTOR, Q.C.:

15 Q. On any documents forwarded externally must go

16 through the director level first prior to

17 release and in some cases, where necessary, go

18 through the executive.

19 MS. JONES:

20 A. Go through the executive.

21 CHAYTOR, Q.C.:

22 Q. And what you're telling us there is whatever

23 documentation goes out, goes through the

24 director. If it's intended for a briefing

25 note, it goes through the executive, is that

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1 what you're saying?

2 MS. JONES:

3 A. That would be what our intention would be.

4 CHAYTOR, Q.C.:

5 Q. Okay, and this whole idea of briefing notes

6 going to the minister, sent directly to the

7 minister from Eastern Health, not being

8 protected, but those that go from the minister

9 to the Cabinet being protected, you understand

10 that to be the case.

11 MS. JONES:

12 A. Yes. So any information that we give to the

13 department is not protected information.

14 CHAYTOR, Q.C.:

15 Q. If it goes directly to the minister.

16 MS. JONES:

17 A. Yeah, and I don't know at any point where we

18 would be sending something directly to

19 Cabinet, we often get a, you know, central

20 government is looking for information, but

21 it's always coming through the department.

22 CHAYTOR, Q.C.:

23 Q. What did this have to do with the discussion

24 that Dr. Hogan's concern? How is this

25 relevant to that?

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1 MS. JONES:

2 A. I think the discussion here if you talk about

3 it is all on briefing notes and that was one

4 issue that we had asked for that Dr. Hogan was

5 looking for an ethic consult because he was

6 very concerned about private patient

7 information going into a departmental focus

8 that was private patient information and I'm

9 sure that the discussion then broadened to the

10 entire aspect of briefing notes.

11 CHAYTOR, Q.C.:

12 Q. So the whole issue of briefing note going to a

13 minister that ultimately goes to Cabinet being

14 protected, that's something that was discussed

15 at executive management?

16 MS. JONES:

17 A. It would have, according to these minutes and,

18 you know, that's two years ago. I can't

19 remember the context, but I definitely know

20 what the first part was all about because

21 there was a lot--we had an individual

22 physician who was very upset and I do remember

23 that.

24 THE COMMISSIONER:

25 Q. And why do they have a reference to

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1 "confidential watermark"?

2 MS. JONES:

3 A. Being that, just like you would have draft on

4 it, anything that would go, we would want it

5 to say "confidential" and that never did

6 action -

7 THE COMMISSIONER:

8 Q. So you would acknowledge that anything you

9 sent to the minister could go anywhere?

10 MS. JONES:

11 A. Could go anywhere. And I can tell you that

12 that was never actioned, I don't know of

13 anything that really goes through even last

14 week when I had to do something, we didn't put

15 "confidential" on it, right.

16 CHAYTOR, Q.C.:

17 Q. So that has not become -

18 MS. JONES:

19 A. That has not become practice.

20 CHAYTOR, Q.C.:

21 Q. But the last sentence here about documents

22 forwarded externally, that is the practice and

23 remains the practice that it must go through

24 the director level and if it's briefing notes,

25 through the executive level.

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1 MS. JONES:

2 A. Yes, and I reinforce that when I had a

3 meeting, when I came in this role in September

4 where I had senior management come together

5 where we were having a fair number of calls

6 inside the organization, us not knowing all of

7 the bits and pieces of information that were

8 going up and so, really I implored both

9 physicians, as well as senior managers who

10 were in that room that day, to make sure that

11 they executive is in tune with what the

12 department is asking for and if in fact, not

13 to make it cumbersome, but that the executive,

14 particularly on sensitive issues need to know

15 and be party to the discussion and what goes

16 forward.

17 CHAYTOR, Q.C.:

18 Q. Ms. Jones, do you know of any instances where

19 there was thought given to giving information

20 which may be of a sensitive and confidential

21 nature and efforts being made by Eastern

22 Health to somehow protect it by sending it

23 through with the intent that it end up in

24 Cabinet?

25 MS. JONES:

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1 A. No.

2 CHAYTOR, Q.C.:

3 Q. You don't know of any incident?

4 MS. JONES:

5 A. I don't know of anything.

6 CHAYTOR, Q.C.:

7 Q. And this again is June 2006 and this had

8 nothing to do with the ER/PR issue?

9 MS. JONES:

10 A. No, it didn't.

11 CHAYTOR, Q.C.:

12 Q. And we've heard from then Minister Osborne

13 that the briefing note that I mentioned to you

14 that Heather Predham's name is attached as

15 being one of the drafters or contributors that

16 ended up in the premier's office, that

17 happened in August of 2006.

18 MS. JONES:

19 A. Yes.

20 CHAYTOR, Q.C.:

21 Q. 2006, so a couple of months after this

22 discussion and Minister Osborne was somewhat

23 taken back that he had never seen the briefing

24 note. So that's just a coincidence that this

25 is in your--being discussed at executive

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1 management at this point in time.

2 MS. JONES:

3 A. Uh-hm, yes, they're totally unrelated.

4 CHAYTOR, Q.C.:

5 Q. Totally unrelated.

6 MS. JONES:

7 A. Totally unrelated.

8 THE COMMISSIONER:

9 Q. When you find a convenient spot, we'll take

10 the afternoon break.

11 CHAYTOR, Q.C.:

12 Q. Okay, that's fine.

13 THE COMMISSIONER:

14 Q. Okay, fifteen.

15 (RECESS)

16 THE COMMISSIONER:

17 Q. Please be seated. Ms. Chaytor?

18 CHAYTOR, Q.C.:

19 Q. Commissioner, I have bad news, yet another

20 exhibit.

21 THE COMMISSIONER:

22 Q. Okay, what number is this one?

23 CHAYTOR, Q.C.:

24 Q. I'm sorry, Ms. Jones, but this is the one that

25 you've been very gracious in getting for us

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1 quickly, 0784 and it's the letter that Ms.
 2 Jones referred to and the package attached to
 3 the letter that she found in Mr. Tilley's
 4 office when she assumed the role.
 5 THE COMMISSIONER:
 6 Q. Okay, so that's P-0784 entered.
 7 EXHIBIT ENTERED AND MARKED P-0784
 8 CHAYTOR, Q.C.:
 9 Q. Thank you. We might as well go right to that
 10 exhibit then, if we could, 0784, please
 11 Registrar? Okay, Ms. Jones, this is the
 12 letter, I take it, that you found on your
 13 first day sitting in your new office?
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. Yes, okay, May 30th, 2007 it's dated.
 18 MS. JONES:
 19 A. That's right, yes.
 20 CHAYTOR, Q.C.:
 21 Q. And it's indicated to be delivered by a
 22 courier?
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. And it's a letter addressed to Mr. John
 2 Abbott, Deputy Minister of Health.
 3 MS. JONES:
 4 A. Uh-hm.
 5 CHAYTOR, Q.C.:
 6 Q. "Dear John, sincerely George Tilley", not
 7 signed, president and chief executive office.
 8 MS. JONES:
 9 A. Yeah.
 10 CHAYTOR, Q.C.:
 11 Q. And enclosing five reports.
 12 MS. JONES:
 13 A. Yes.
 14 CHAYTOR, Q.C.:
 15 Q. And those five reports being what?
 16 MS. JONES:
 17 A. Well we would have had the Banerjee and the
 18 Trish -
 19 CHAYTOR, Q.C.:
 20 Q. Wegrynowski.
 21 MS. JONES:
 22 A. - original reports and the six-month follow
 23 up and I'm not sure, it says five.
 24 CHAYTOR, Q.C.:
 25 Q. Yes, now if we read down through the letter,

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1 it also refers to "the report prepared by Dr.
 2 Allen Gown".
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. "Was requested by HIROC and therefore not ours
 7 to release."
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. Was that report also in the package that you
 12 found on his desk?
 13 MS. JONES:
 14 A. I didn't read that report. This actual
 15 package, when I picked it up from my secretary
 16 today, there was an attachment to it with
 17 little pink things on it, which would have
 18 been me reading the report, that was the
 19 original report that I read, right.
 20 CHAYTOR, Q.C.:
 21 Q. Okay.
 22 MS. JONES:
 23 A. But the Gown report, I don't know.
 24 CHAYTOR, Q.C.:
 25 Q. The Gown report was included though in the

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1 package, I take it?
 2 MS. JONES:
 3 A. I don't know, I just picked the package -
 4 CHAYTOR, Q.C.:
 5 Q. Was included in -
 6 COFFEY, Q.C.:
 7 Q. Just if I could, Commissioner, just so we're
 8 clear, the packages delivered to us today by
 9 Mr. Simmons included a Gown report. Now as
 10 soon as that was identified, Commissioner, I
 11 saw Gown's name on it and in fact, you would
 12 have, some people in the room would have seen
 13 it, I walked in late and I passed, other than
 14 identifying Dr. Gown's name, I gave it back to
 15 Mr. Simmons because, of course, it would be
 16 solicitor/client privilege, so it was in the
 17 package.
 18 MS. JONES:
 19 A. Okay, and I did -
 20 COFFEY, Q.C.:
 21 Q. Just to let you know, it was identified as G6.
 22 MR. SIMMONS:
 23 Q. Madam Commissioner, I want to thank Mr. Coffey
 24 for noting that. The package arrived just
 25 minutes before we started lunchtime and we

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1 passed it directly on without realizing that
 2 other document was part of it, Mr. Coffey
 3 graciously recognized that.
 4 THE COMMISSIONER:
 5 Q. Thank you.
 6 CHAYTOR, Q.C.:
 7 Q. So it appears then that the package that you
 8 would have found would have included the two--
 9 Ms. Wegrynowski's reports, two Dr. Banerjee's
 10 and one report from Dr. Allen Gown.
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. Now if we read the letter, though, it says
 15 that "Further to your request, I am attaching
 16 reports that were prepared in relation to the
 17 ER/PR issue. Please note that the reports
 18 prepared by Trish Wegrynowski and Dr. Banerjee
 19 were prepared as a peer review request and to
 20 that extent, we have performed it under our
 21 quality umbrella to ensure its protection from
 22 future release. The report prepared by Dr.
 23 Allen Gown was requested by HIROC and
 24 therefore, not ours to release. If need be,
 25 we can arrange to have the laboratory leaders

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1 present on these items." Now, Mr. Coffey is
 2 just indicating to me here that there was also
 3 included in the package the review of
 4 immunohistochemistry lab by Terry Gulliver,
 5 October 13th, 2005. So perhaps that was the
 6 fifth report that was to be included.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. In what was going to the department.
 11 MS. JONES:
 12 A. Uh-hm.
 13 CHAYTOR, Q.C.:
 14 Q. I guess only Mr. Tilley will be able to tell
 15 us that when he comes back.
 16 MS. JONES:
 17 A. That's right and initially when I picked it up
 18 at the office today, if you just scroll down,
 19 I thought that was my signature, but that is
 20 not my writing, so -
 21 CHAYTOR, Q.C.:
 22 Q. This "never sent"?
 23 MS. JONES:
 24 A. Yeah, I thought it was and maybe if I saw the
 25 original, when I looked at it quickly, I

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1 thought that was mine, as I crossed out and
 2 sometimes -
 3 CHAYTOR, Q.C.:
 4 Q. We can get the original.
 5 CHAYTOR, Q.C.:
 6 Q. - the resolution on the computer is not very
 7 good because initially I did actually think
 8 that I had crossed it and just said never
 9 sent, file it away.
 10 CHAYTOR, Q.C.:
 11 Q. Yes, because I was going to ask if you had
 12 written that, how would you know it was never
 13 sent?
 14 MS. JONES:
 15 A. Because I asked the secretary.
 16 CHAYTOR, Q.C.:
 17 Q. Who is Joyce Penney?
 18 MS. JONES:
 19 A. Joyce Penney, did she ever remember sending
 20 this and she said no.
 21 CHAYTOR, Q.C.:
 22 Q. So she hadn't remembered sending it?
 23 MS. JONES:
 24 A. That's right.
 25 CHAYTOR, Q.C.:

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1 Q. And it says "delivered via courier" on the
 2 top?
 3 MS. JONES:
 4 A. Yes, that would have been--Joyce would have
 5 printed the letter and that would have
 6 probably been the intent that it was to go by
 7 courier.
 8 CHAYTOR, Q.C.:
 9 Q. And the letter was to be cc'd to Dr. Howell
 10 and Heather Predham.
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. And did you ask either of those individuals if
 15 they ever received a copy of this letter?
 16 MS. JONES:
 17 A. I would suspect that at this point in time
 18 where it's not gone out, that Ms. Penney, I
 19 can ask that question, whether she would have
 20 ever sent -
 21 CHAYTOR, Q.C.:
 22 Q. So you have the original now?
 23 MS. JONES:
 24 A. That's not my writing.
 25 CHAYTOR, Q.C.:

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1 Q. That's not your writing. So when you picked
 2 this up and was it already marked on?
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. So when you picked -
 7 MS. JONES:
 8 A. That's not my writing.
 9 CHAYTOR, Q.C.:
 10 Q. When you picked it up "never sent" was already
 11 written on it and it was already crossed off?
 12 MS. JONES:
 13 A. Yes, "never sent".
 14 CHAYTOR, Q.C.:
 15 Q. And it was already crossed off.
 16 MS. JONES:
 17 A. Uh-hm.
 18 CHAYTOR, Q.C.:
 19 Q. So that's the way you found the package.
 20 MS. JONES:
 21 A. That's the way I found the package on the desk
 22 right here, on the front of the desk.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and you're showing on the top of the
 25 desk?

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. So it was on the--was it buried underneath
 5 anything or was it in plain view on top?
 6 MS. JONES:
 7 A. There may have been lots of things on top of
 8 it, okay, because the two file trays are here
 9 and the report, by the time I got down to what
 10 was on the desk, this is what I found and I
 11 thought, okay, never sent.
 12 CHAYTOR, Q.C.:
 13 Q. But it was actually on the top of the desk.
 14 MS. JONES:
 15 A. Yeah, it was on the desk in the office.
 16 CHAYTOR, Q.C.:
 17 Q. And not in any drawer.
 18 MS. JONES:
 19 A. No, I don't ever remember finding it in the
 20 drawer.
 21 CHAYTOR, Q.C.:
 22 Q. So your recollection is on the top of your
 23 desk?
 24 MS. JONES:
 25 A. Right there.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. And it included the, obviously, the
 3 reports of Trish Wegrynowski and Dr. Banerjee.
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. And I just want to be clear because in
 8 mentioning the Gown report a few minutes ago,
 9 you said you didn't read that, you've never
 10 read that report, I take it?
 11 MS. JONES:
 12 A. No, well I didn't even--well now that you say
 13 it, I would have understood that HIROC would
 14 have done a report, but Allen Gown is not a
 15 name even that Dan Boone would have ever said
 16 anything to me about.
 17 CHAYTOR, Q.C.:
 18 Q. When you find this package, you gave it--you
 19 asked Joyce Penney whether or not she had
 20 recalled ever sending it.
 21 MS. JONES:
 22 A. Uh-hm.
 23 CHAYTOR, Q.C.:
 24 Q. And why would you have to ask her that if it's
 25 got crossed off "never sent" written on it?

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1 MS. JONES:
 2 A. Because I know by looking at the names that
 3 these are peer review, okay, documents that
 4 Dr. Banerjee documents and to send them to the
 5 department when we had always talked about
 6 them being peer review and protected under the
 7 Evidence Act, that was a very unusual--I was
 8 very surprised to see that.
 9 CHAYTOR, Q.C.:
 10 Q. So Mr. Tilley, your predecessor in thinking
 11 that the department was an extension, I think
 12 was his word, so in sending it to--he also was
 13 of the view they were peer review or an
 14 understanding that that's what they were being
 15 classified as, but he obviously was going to
 16 send it on to Mr. Abbott when Mr. Abbott
 17 requested it and saw the department as some
 18 sort of extension.
 19 MS. JONES:
 20 A. You'll have to ask -
 21 CHAYTOR, Q.C.:
 22 Q. That's not your view?
 23 MS. JONES:
 24 A. That would not have been my view.
 25 CHAYTOR, Q.C.:

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1 Q. That would not have been your view.
 2 MS. JONES:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. So even though your predecessor was prepared
 6 to send it to the department, you would not
 7 have been?
 8 MS. JONES:
 9 A. And I did not.
 10 CHAYTOR, Q.C.:
 11 Q. And you did not, okay. So you went on to ask,
 12 even though it had "never sent" written on the
 13 letter with crossed out, you still asked Mrs.
 14 Penney whether or not this had in fact been
 15 sent?
 16 MS. JONES:
 17 A. Yes. And she would have, because "by courier"
 18 would have meant that there would have had to
 19 be some arrangement that she would have had to
 20 make.
 21 CHAYTOR, Q.C.:
 22 Q. Yes, so why did you want to reassure yourself
 23 on that?
 24 MS. JONES:
 25 A. Oh just everything on this desk was very new

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1 and I was not aware of the process that Mr.
 2 Tilley would have had with working with his
 3 secretary and that, and this is the 9th of
 4 July, so here we have -
 5 CHAYTOR, Q.C.:
 6 Q. I'm sorry, when you are finding this -
 7 MS. JONES:
 8 A. Well it wouldn't have been the 9th of July
 9 because there were too many things going on,
 10 even the 9th, 10th and 11th, but by the time I
 11 worked my way down through the desk, in terms
 12 of seeing what was there and what was on the
 13 desk, this faced me. And knowing "never sent"
 14 meant that he obviously had gone to the
 15 process of dictating a letter or writing a
 16 letter and having it printed, but not sending
 17 it.
 18 CHAYTOR, Q.C.:
 19 Q. Did you ever ask or have occasion to speak to
 20 Mr. Tilley about this?
 21 MS. JONES:
 22 A. No.
 23 CHAYTOR, Q.C.:
 24 Q. And what about Dr. Howell or Heather Predham,
 25 they are cc'd on the letter?

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1 MS. JONES:
 2 A. I didn't talk to them, I just assumed that the
 3 whole thing was not sent.
 4 CHAYTOR, Q.C.:
 5 Q. So you don't know if they received the letter
 6 or not or--did you make inquiries as to how
 7 Mr. Tilley would have the reports in his
 8 possession?
 9 MS. JONES:
 10 A. No. Mr. Tilley was gone by that time.
 11 CHAYTOR, Q.C.:
 12 Q. So you didn't ask Mr.--Dr. Howell for example?
 13 MS. JONES:
 14 A. No.
 15 CHAYTOR, Q.C.:
 16 Q. But you felt that you weren't going to read
 17 the reports yourself, you gave them to Mrs.
 18 Penney.
 19 MS. JONES:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. What did she do with the reports?
 23 MS. JONES:
 24 A. She filed them away. When I called today, she
 25 had them, wherever secretaries file stuff that

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1 they -
 2 CHAYTOR, Q.C.:
 3 Q. Within your office, though, I take it?
 4 MS. JONES:
 5 A. Yes, within our office.
 6 CHAYTOR, Q.C.:
 7 Q. So she had the reports, copies of the reports
 8 in your office.
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. And was able to put her hands on it fairly
 13 quickly and you weren't curious when you found
 14 this sitting on your desk, you weren't curious
 15 to say -
 16 MS. JONES:
 17 A. Well I said, actually as I said to you this
 18 morning, I did have to read the reports.
 19 CHAYTOR, Q.C.:
 20 Q. Yes, but at the time when you first discovered
 21 them.
 22 MS. JONES:
 23 A. I guess in the CEO role I would have expected
 24 at some point to probably have a look at them
 25 or at least be aware of, but that was not

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1 anywhere in my--in the front of what I was
 2 doing and it was only when we had to start
 3 having the discussion about releasing the
 4 reports here that I really gave an in-depth
 5 review of them to see what was in them.
 6 CHAYTOR, Q.C.:
 7 Q. So you didn't until they were to be released -
 8 MS. JONES:
 9 A. Until we had to make a decision about where
 10 the Commission would--whether we should be
 11 releasing to the Commission, the reports.
 12 CHAYTOR, Q.C.:
 13 Q. So it's not that as acting CEO or interim CEO,
 14 it's not that you didn't think--did you think
 15 you had the right to read the reports?
 16 MS. JONES:
 17 A. I hadn't even given it any process at the
 18 point in time, remembering I came into this
 19 particular job with Burin radiology, as well
 20 as getting ready for Commission of Inquiry, as
 21 well as everything else that was on the desk,
 22 so it would have been even two weeks or more
 23 before I would have gotten down to knowing all
 24 of the bits and pieces and really, you were
 25 triaging on a daily basis with respect to what

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1 I needed to deal with today, what I needed to
 2 deal with--and so it was only when I got to
 3 the full scope of what was going on in the
 4 office, after I had set up a structure to
 5 prepare us for the inquiry, to meet with the
 6 solicitors, all of those kinds of things, that
 7 the technical parts of all of this would have
 8 come into my head about what was going on with
 9 ER/PR, where it was, because as you've heard
 10 me say, there was very little intimate
 11 knowledge about that whole issue and at that
 12 point in time, we already had the discussion
 13 going on and it's towards the latter part of
 14 July where peer review was coming up with
 15 respect to what was our position, as Eastern
 16 Health, going to be with respect to the peer
 17 review reports.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, I just want to be clear because I
 20 understand then, I'm going to ask you what you
 21 understood the status of the ER/PR issue to be
 22 when you assumed the role.
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. But on this particular issue about you are now
 2 the CEO and you find this on the desk of the
 3 CEO.
 4 MS. JONES:
 5 A. Yes.
 6 CHAYTOR, Q.C.:
 7 Q. So obviously your predecessor had these
 8 documents in his possession.
 9 MS. JONES:
 10 A. Uh-hm.
 11 CHAYTOR, Q.C.:
 12 Q. What was your understanding as to your
 13 entitlement to have these documents and be
 14 able to read these documents?
 15 MS. JONES:
 16 A. And honestly if I was to process it, I would
 17 have said that this was between the leadership
 18 teams, okay, and Dr. Williams or Dr. Howell in
 19 terms of moving forward, because that is why,
 20 that's the whole idea of peer review and
 21 inside the quality committee of the
 22 organization, so they're protected under the
 23 Evidence Act. So that would have been my
 24 initial processing, until I had time to sit
 25 down and see just exactly where we go. I had

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1 been involved in peer review in the past and
 2 in my role as COO would have been part of the
 3 leadership team, that it would have been
 4 responsible and been able to see what was
 5 inside of peer review as part of that
 6 leadership team.
 7 CHAYTOR, Q.C.:
 8 Q. Yes, and peer review involving particularly
 9 named doctors or professionals?
 10 MS. JONES:
 11 A. Yes, absolutely.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, and I take it we don't see that in these
 14 reports?
 15 MS. JONES:
 16 A. No, not in particular individuals.
 17 CHAYTOR, Q.C.:
 18 Q. So you gave it to Ms. Penney and she filed it
 19 away and then sometime down the road, you--
 20 these are the copies that you actually read?
 21 MS. JONES:
 22 A. Those were the copies that I initially read,
 23 yes.
 24 CHAYTOR, Q.C.:
 25 Q. So you went back to Ms. Penney and asked her

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1 to retrieve the file?
 2 MS. JONES:
 3 A. Retrieve them, I needed to see what was in
 4 them, we had to make a decision with respect
 5 to the Commission of Inquiry.
 6 CHAYTOR, Q.C.:
 7 Q. Whether to disclose them through this process.
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. Yes. Did Mr. Thompson ever request copies of
 12 the reports?
 13 MS. JONES:
 14 A. Mr. Thompson requested findings of
 15 recommendations of peer review. There was a
 16 listing of information that through July or
 17 into early August he had asked, as they were
 18 preparing the department for the Commission,
 19 for a list of, there's maybe 18 things and
 20 peer review, findings of recommendations of
 21 peer review conducted in 2005 were there on
 22 that list and the discussion I had with -
 23 CHAYTOR, Q.C.:
 24 Q. I'm sorry, could you tell me that again?
 25 Which document are you referring to?

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1 MS. JONES:
 2 A. It's just a list of required documents that
 3 the department was looking for, that we've co-
 4 ordinated through Mr. Simmons in terms of
 5 moving those through to the department.
 6 CHAYTOR, Q.C.:
 7 Q. So that's your own document that you created
 8 based on -
 9 MS. JONES:
 10 A. This was a document that Robert Thompson had
 11 and asked us to--and it had everything from
 12 job descriptions on it to a DAKO and Ventana
 13 operating manuals, to findings of
 14 recommendations of peer review conducted in
 15 2005. And I clearly said to him at the time
 16 that they were peer review documents and that
 17 they would not be moving forward.
 18 THE COMMISSIONER:
 19 Q. Just to make it clear, Mr. Thompson, for
 20 whatever reason, sent you a shopping list, as
 21 it were, of things that he wanted from the
 22 organization.
 23 MS. JONES:
 24 A. Eastern Health, that's right.
 25 THE COMMISSIONER:

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1 Q. And you were prepared to give him 17 of those
 2 things and not the 18th?
 3 MS. JONES:
 4 A. Very clearly I talked to Robert and I was not
 5 prepared to give him the peer review
 6 recommendations because I was still under the
 7 impression of peer review and that therefore,
 8 they should not be shared outside of the
 9 structures inside of which they were
 10 protected.
 11 CHAYTOR, Q.C.:
 12 Q. What's the date of the document? I don't have
 13 that document?
 14 MS. JONES:
 15 A. There is no date on the document, but that
 16 would have been sometime in August or so,
 17 July, August.
 18 CHAYTOR, Q.C.:
 19 Q. August of 2007?
 20 MS. JONES:
 21 A. Yeah.
 22 CHAYTOR, Q.C.:
 23 Q. And Mr. Thompson forwarded this to you?
 24 MS. JONES:
 25 A. Yes, that was a list of documents and I'm

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1 thinking that Mr. Simmons also had, but we
 2 would have shared with him the types of
 3 information that the department was looking
 4 for.
 5 CHAYTOR, Q.C.:
 6 Q. Okay, and what is it exactly with respect to
 7 the peer review documents that Mr. Thompson
 8 asked to be provided?
 9 MS. JONES:
 10 A. He's asking for findings and recommendations
 11 of the peer review conducted in 2005.
 12 CHAYTOR, Q.C.:
 13 Q. Okay, so he's asking for the findings and the
 14 recommendations?
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And what was your response to Mr. Thompson?
 19 MS. JONES:
 20 A. And my response was because they are a peer
 21 review, that we wouldn't be providing them and
 22 that we were working through a process around
 23 what response we were going to work through
 24 for the Commission and once I had had some
 25 legal advice, then as we move forward, we

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1 would discuss them.
 2 CHAYTOR, Q.C.:
 3 Q. And did you communicate that directly back to
 4 Mr. Thompson?
 5 MS. JONES:
 6 A. Yes.
 7 CHAYTOR, Q.C.:
 8 Q. Was there e-mails back?
 9 MS. JONES:
 10 A. No, they would have probably been verbal
 11 conversation.
 12 CHAYTOR, Q.C.:
 13 Q. Verbal conversations. And at that point in
 14 time, did you inform him that Mr. Tilley had
 15 been prepared to give the documents to Mr.
 16 Abbott?
 17 MS. JONES:
 18 A. No, I didn't.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, and why not?
 21 MS. JONES:
 22 A. Because this says "never sent" so I'm not sure
 23 what the conversation between Mr. Abbott and
 24 Mr. Tilley--there is obviously a reason why
 25 Mr. Tilley didn't send that document.

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1 CHAYTOR, Q.C.:
 2 Q. Yes, and I think Mr. Tilley's answer to that
 3 was because Mr. Abbott wasn't there to send it
 4 to.
 5 MS. JONES:
 6 A. Well that could very well be.
 7 CHAYTOR, Q.C.:
 8 Q. If I recall Mr. Tilley's evidence on it.
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. So when Mr. Thompson comes looking for it,
 13 less than two months later -
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. You make a different decision than Mr. Tilley
 18 made.
 19 MS. JONES:
 20 A. Absolutely.
 21 CHAYTOR, Q.C.:
 22 Q. And the reason for that was what?
 23 MS. JONES:
 24 A. Because my full belief was, in terms of the
 25 issue of these were peer review documents,

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1 that is what we had been talked--that had been
 2 talked about inside the organization for the
 3 entire two years. There's also much
 4 discussion within the medical staff, as well
 5 as the organization, not just over these
 6 documents, but any reviews that were like that
 7 to be protected under peer review and
 8 underneath the Evidence Act. So really having
 9 a set of documents that individuals and
 10 physicians and staff believe were protected,
 11 it really would be breaking their confidence.
 12 CHAYTOR, Q.C.:
 13 Q. You had read the documents by this point in
 14 time?
 15 MS. JONES:
 16 A. By that time I had read them, I knew what was
 17 in them.
 18 CHAYTOR, Q.C.:
 19 Q. Okay, and you knew what wasn't in them as
 20 well.
 21 MS. JONES:
 22 A. And I knew what wasn't in them.
 23 CHAYTOR, Q.C.:
 24 Q. Including no reference to individual names?
 25 MS. JONES:

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1 A. Yes. And I think you also need to understand
 2 that in terms of the Evidence Act, we were
 3 also very clear that it didn't have to be
 4 individual peer review, quality assurance
 5 activities are protected under the Act, just
 6 like incident reports and even our policies
 7 today talk about incident occurrence reporting
 8 being protected underneath the Evidence Act.
 9 CHAYTOR, Q.C.:
 10 Q. This letter that Mr. Tilley had drafted says
 11 that "they were prepared as a peer review
 12 request and to that extent, we have performed
 13 it under our quality umbrella to ensure its
 14 protection from future release." Is that why
 15 these documents were classified in that
 16 manner?
 17 MS. JONES:
 18 A. I have no idea because I wasn't in in any of
 19 the initial discussions around bringing in
 20 external review individuals. We often set up
 21 peer review, whether it's on an individual
 22 basis, usually and we do set it up in a
 23 fashion underneath the Evidence Act.
 24 CHAYTOR, Q.C.:
 25 Q. And Ms. Jones, were you aware that--and I

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1 think it may have actually been the day after
 2 this, May 31st, 2007, certainly late May, that
 3 the recommendations had been provided to the
 4 department or a spreadsheet with the
 5 recommendations?
 6 MS. JONES:
 7 A. No, I wouldn't have.
 8 CHAYTOR, Q.C.:
 9 Q. Nobody told you that?
 10 MS. JONES:
 11 A. Nobody told me that and if that was so, I'm
 12 surprised to see that they were on the list
 13 that Mr. Thompson had, because if they were in
 14 the department, he would have had -
 15 CHAYTOR, Q.C.:
 16 Q. He may have been looking for an updated list,
 17 I think the list that was sent to him was
 18 about a year old.
 19 MS. JONES:
 20 A. Yeah.
 21 CHAYTOR, Q.C.:
 22 Q. So, what were you told was the status of the
 23 ER/PR issue when you assumed this position?
 24 MS. JONES:
 25 A. That we had been doing a--working on the

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1 recommendations inside of the individual peer
 2 reviews, that we had restarted testing inside
 3 St. John's in the winter of 2007. That we
 4 were continuing to work on any of the
 5 recommendations that were still left
 6 outstanding.
 7 CHAYTOR, Q.C.:
 8 Q. So, you understood that there were
 9 recommendations yet to be implemented?
 10 MS. JONES:
 11 A. Yes, being small parts, maybe policy areas
 12 that had not actually been totally signed off.
 13 CHAYTOR, Q.C.:
 14 Q. And who did you meet with to get a briefing on
 15 the issue?
 16 MS. JONES:
 17 A. It would have been Oscar Howell at the time
 18 because the lab reported into Dr. Howell. The
 19 other thing that I would have done at that
 20 point in time is because we were getting ready
 21 for--we knew that the Commission of Inquiry
 22 had been named and we needed to prepare the
 23 organization for it. We did some executive
 24 restructuring that moved Ms. Pilgrim in a lead
 25 role to prepare for the Commission versus the

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1 ER/PR. So that was part of us moving forward
 2 to get ready for coming into the Commission of
 3 Inquiry.
 4 CHAYTOR, Q.C.:
 5 Q. Where did you understand the disclosure piece
 6 was by the time you took over?
 7 MS. JONES:
 8 A. In what sense?
 9 CHAYTOR, Q.C.:
 10 Q. July, 2007. In terms of contact with the
 11 patients, did you understand they had all been
 12 identified and contacted?
 13 MS. JONES:
 14 A. There had been lots of discussion around and
 15 even as we were going in through, before I
 16 came on, it would always be said that, "Yes,
 17 we have contacted all of the patients" and
 18 then there would be somebody who had come
 19 forward in the medial that say "I had not been
 20 contacted." So and every time we had gone and
 21 looked at that, there was--there always was an
 22 issue. Either it had been a patient who had
 23 not been identified to be sent for retesting
 24 or a patient that--and it wasn't generally a
 25 patient that had not been contacted with the

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1 results follow-up, but it was generally, you
 2 know, patients who had not been sent forward.
 3 CHAYTOR, Q.C.:
 4 Q. Okay. So you were aware of that issue even
 5 before you became CEO, that there were
 6 patients coming forward, that Eastern Health
 7 was saying they're all contacted?
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. And then patients would come forward. And so
 12 where was that being discussed, at what level?
 13 MS. JONES:
 14 A. That was being discussed really at the inside
 15 of the quality and because normally the
 16 contact call would come in through either the
 17 cancer program or in through the quality in
 18 terms of the hotline.
 19 CHAYTOR, Q.C.:
 20 Q. But who was telling this to you at the
 21 executive level?
 22 MS. JONES:
 23 A. It would be Mrs. Pilgrim, because it was on
 24 patient contact and that kind of notification
 25 process.

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1 CHAYTOR, Q.C.:

2 Q. And so when the patient would come forward or

3 there'd be notification from a patient that

4 there hadn't been contact, that would be

5 looked into and it would be determined that,

6 yes, the patient hadn't been contacted?

7 MS. JONES:

8 A. Yes. Or in sometimes we were hearing and they

9 have been contacted and we could have

10 identified the date or the time. Or sometimes

11 it was that the patient had never been

12 identified. And we had a number of instances,

13 particularly into the fall of 2005, where

14 patients were not originally identified, and

15 the minister would have talked about those in

16 a November press conference that there were

17 parts of this province that were continuing to

18 send in slides that needed to be sent to Mount

19 Sinai.

20 CHAYTOR, Q.C.:

21 Q. Um-hm. And did--at any point was there

22 discussion about continuing to go out with the

23 same message, that everybody had been

24 contacted?

25 MS. JONES:

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1 A. The board was very clear that, you know, our

2 using of the word "all" was very problematic

3 because every time we used all, there was

4 somebody else who came forward. But in the

5 context of talking to the people who were

6 responsible for that, they would definitely

7 say that they had made the contact. We now

8 know that that is different, as the database

9 that NLCHI has actually put together. They

10 took over that in July when I came on. That

11 process was already in place about building a

12 definitive database, including the contact

13 piece.

14 CHAYTOR, Q.C.:

15 Q. Okay. So it was certainly the subject of

16 discussion at the board and the board was

17 concerned about the use of the word "all"?

18 MS. JONES:

19 A. That's right.

20 CHAYTOR, Q.C.:

21 Q. Was it also a subject of discussion around

22 executive management?

23 MS. JONES:

24 A. Executive table, absolutely.

25 CHAYTOR, Q.C.:

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1 Q. Okay. And is it that they were then

2 reassurances from the people making the

3 contacts that everyone has now been contacted,

4 is that why -

5 MS. JONES:

6 A. We very clearly claimed to the decision that

7 we would--like, at the end of the day the way

8 that this database was developed and was

9 looking, that could we ever say that they were

10 all.

11 CHAYTOR, Q.C.:

12 Q. Yes.

13 MS. JONES:

14 A. Because there was--it was not just Eastern

15 Health, it was all of the other regional

16 health authorities that had to search their

17 own paper trails and that, and that there was

18 no way that we would have that full assurance.

19 The Newfoundland and Labrador Centre for

20 Health Information that was commissioned to

21 develop the database, that was part of their,

22 one of their mandates was to insure that or to

23 search to the best of their ability to insure

24 that we had all of the individuals in the

25 province.

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1 CHAYTOR, Q.C.:

2 Q. I just want to back up to the piece where the

3 assurances were still going out that all the

4 patients had been contacted and that happened

5 on more than one occasion. And Minister

6 Wiseman has said that he was relying on

7 information, as well, from Eastern Health in

8 his assertions in that regard. So at some

9 point is it at the board level that a

10 conscious decision is made to be careful,

11 don't be saying they're all contacted, there

12 are some that we don't even have any control

13 over or knowledge as to whether or not they're

14 contacted?

15 MS. JONES:

16 A. And I think that that would have been jointly,

17 because we would have been saying there's no

18 way that we have that confidence in this

19 database because we cannot, we can't assure

20 ourselves that we could get at everything for

21 a ten-year period of time.

22 CHAYTOR, Q.C.:

23 Q. And when did that lack of confidence happen?

24 MS. JONES:

25 A. I think that that happened long before Mr.

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1 Tilley left.
 2 CHAYTOR, Q.C.:
 3 Q. Okay. So that's long before Mr. Tilley left?
 4 MS. JONES:
 5 A. Yeah, in, you know, as we came up through and
 6 every time there would be some other
 7 disclosure in the public coming forward, they
 8 would say "How can that happen?" And when you
 9 chase back, it wasn't in the original
 10 database, you were back into original reports,
 11 maybe it was one of the regional health
 12 authorities in their original review of the
 13 reports didn't send forward that particular
 14 patient, didn't identify them as part of the
 15 retesting set of individuals.
 16 CHAYTOR, Q.C.:
 17 Q. So that discussion and the lack of confidence
 18 in the database that had been put together by
 19 Eastern Health, that happened long before Mr.
 20 Tilley left?
 21 MS. JONES:
 22 A. Absolutely.
 23 CHAYTOR, Q.C.:
 24 Q. And what do you mean by "long before", how
 25 many -

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1 MS. JONES:
 2 A. Probably in the two months before. We ran
 3 into--I know before I came on on the 9th of
 4 July there was discussion around Eastern
 5 Health trying to go back and recreate what had
 6 been done. And that was to develop a
 7 consolidated or a single database that would
 8 have all of the clients that were identified
 9 that we could, as well as all of the contacts
 10 to put it in a single source. I think you
 11 will hear clearly from many individuals that
 12 we had a list of 939 that were identified in
 13 the lab, is what the lab had identified. And
 14 then we had another list, a contact list in
 15 terms of what information or who had contacted
 16 patients, how many patients were panelled, how
 17 we had sent out to the different regional
 18 health authorities who assisted us in
 19 contacting individual patients. So there was
 20 clearly a need to put that into a single
 21 database and to sign down and make sure all of
 22 the components were locked. When I came into
 23 the role, Mr. Tilley and Mr. Thompson had
 24 already had discussions about that and it was
 25 clear that there would have been no confidence

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1 in Eastern Health developing that database and
 2 that we needed an external third party to
 3 develop that database and that's where the
 4 NLCHI came in. And so there was a contract or
 5 a mandate or whatever between the government,
 6 and what we clearly said at the time was that
 7 we will, they--NLCHI couldn't do their work
 8 without the assistance of Eastern Health and
 9 we were clearly needing to develop many of the
 10 same things that NLCHI was going to develop,
 11 so we would work in concert and at the end of
 12 that then whatever NLCHI was able to
 13 determine, that that database would be
 14 available for Eastern, to Eastern Health to be
 15 able to move forward and do other things with
 16 it. But it was clearly a database that would
 17 identify all of the ER/PR negative as well as
 18 the contacts. So there was two components of
 19 that that should have been complete.
 20 CHAYTOR, Q.C.:
 21 Q. Right. So and the lack of confidence in
 22 Eastern Health's own work on that piece -
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. That had happened a couple of months, you're
 2 saying, before Mr. Tilley left?
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. So that's back in May of 2007?
 7 MS. JONES:
 8 A. May, into June of 2005, for sure. So it was -
 9 CHAYTOR, Q.C.:
 10 Q. 2007?
 11 MS. JONES:
 12 A. 2007, sorry about that.
 13 CHAYTOR, Q.C.:
 14 Q. All right. So it's--and do you know whether
 15 or not that lack of confidence was ever
 16 communicated to the Department of Health prior
 17 to now the discussion later on when -
 18 MS. JONES:
 19 A. I think -
 20 CHAYTOR, Q.C.:
 21 Q. - you're into putting together NLCHI's
 22 database?
 23 MS. JONES:
 24 A. I think that that was a discussion, and I
 25 don't know, you'll have to ask Mr. Tilley

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1 about that, that as we were going to go down
 2 the road of developing or attempting to come
 3 at this from a different way, then there was
 4 the discussion. So you'll have to talk to
 5 Robert Thompson and to Mr. Tilley about that
 6 particular conversation. When I came in on
 7 the 9th of July, I actually had my first
 8 meeting with Robert Thompson on the 19th and
 9 that was one of the issues that we did
 10 discuss. Because the individuals inside my
 11 organization were carrying on a full-time role
 12 running the lab or doing the quality or
 13 whatever and they--the NLCHI, as I said,
 14 couldn't do the work without them, so this was
 15 after hours, evenings, weekends, so they were
 16 carrying a regular workload as well as this.
 17 And we had discussions about how can we
 18 streamline this so that you get what you need
 19 and that we are able to at the end of the day
 20 be confident and to be able to take that
 21 database and move forward.
 22 CHAYTOR, Q.C.:
 23 Q. Right, okay. So and you're thinking when you
 24 come into this job on July 9th the lack of
 25 confidence in your own organization for your

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1 database had been going on for a couple of
 2 months?
 3 MS. JONES:
 4 A. Had been going on for awhile. Whether it was
 5 a couple of months or not is another story.
 6 CHAYTOR, Q.C.:
 7 Q. And when that may have been communicated to
 8 the department, you don't know?
 9 MS. JONES:
 10 A. And I think that it may have come the other
 11 way. You're making an assumption that we
 12 communicated with that with the department. I
 13 think that that may very well have been a
 14 discussion about the feeling about Eastern
 15 Health's ability to be able to develop a
 16 database given the experience of Burin.
 17 CHAYTOR, Q.C.:
 18 Q. So the department, in fact--yeah. So you're
 19 suggesting the department was -
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. - the precipitator of that in saying that,
 24 well, perhaps you don't know for sure?
 25 MS. JONES:

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1 A. And I would say to you that that was a
 2 discussion that I would have had with the
 3 department and it was not one that I would
 4 have said, "Look, if we're going to go down
 5 this road, I don't want two sets of people out
 6 there developing a database because what does
 7 that mean. Let's let this Newfoundland and
 8 Labrador Centre for Health Information has
 9 this expertise in database management and
 10 building databases, so thank you, very much,
 11 let's use them" and then take that and work it
 12 with what we needed it inside Eastern Health.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, right.
 15 MS. JONES:
 16 A. So it wasn't something that I was going to
 17 fight the department on.
 18 CHAYTOR, Q.C.:
 19 Q. No, no, no, I'm not suggesting. My question
 20 is more geared towards if we're into May, 2007
 21 and Eastern Health has recognized that there's
 22 some issue or lack of confidence themselves in
 23 their work on this piece, when Eastern Health
 24 may have communicated that to the department.

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1 And what you're saying is that that probably
 2 didn't get communicated from Eastern Health,
 3 but the department came to the realization
 4 itself -
 5 MS. JONES:
 6 A. That it needed to develop it.
 7 CHAYTOR, Q.C.:
 8 Q. That there should be a lack of confidence, is
 9 that--that's your answer?
 10 MS. JONES:
 11 A. Yeah, that would be my answer.
 12 CHAYTOR, Q.C.:
 13 Q. That's your answer, okay. When you became
 14 CEO, did you make any changes in terms of the
 15 management of the ER/PR issue?
 16 MS. JONES:
 17 A. What we did is we did some organizational
 18 restructuring so that we would have a senior
 19 executive responsible for that particular
 20 aspect, remembering that the ER/PR technical
 21 issues in terms of the reports were well under
 22 way and, you know, the move forward in the lab
 23 had already restarted testing and that. So on
 24 the other side it was what were the other
 25 things that we needed to do to prepare

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1 ourselves for the Inquiry and anything else
 2 that needed to be done. So Mrs. Pat Pilgrim
 3 took over that role and there were some of her
 4 clinical roles that we moved to other COOs so
 5 we could free her up to be able to do that
 6 particular piece of work and to take the lead
 7 in that. She would have been called the
 8 executive lead.
 9 CHAYTOR, Q.C.:
 10 Q. Okay. And if we could go back, please, there
 11 were a couple of other executive management
 12 meetings that you would have been involved in
 13 before you took over the role.
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. 0774, please, Registrar? And this is an
 18 executive management meeting of November 21st,
 19 2006?
 20 MS. JONES:
 21 A. Yes.
 22 CHAYTOR, Q.C.:
 23 Q. And you are present?
 24 MS. JONES:
 25 A. Um.

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1 CHAYTOR, Q.C.:
 2 Q. And Mr. Tilley is the chairperson?
 3 MS. JONES:
 4 A. Um.
 5 CHAYTOR, Q.C.:
 6 Q. Ah, you're present twice, apparently. Your
 7 name appears twice.
 8 MS. JONES:
 9 A. Okay.
 10 CHAYTOR, Q.C.:
 11 Q. Probably comes in handy some days, I would
 12 think. And the usual people are in attendance
 13 and now Dr. Oscar Howell, of course, is in the
 14 position of VP medical?
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And this, if you--this is a fairly lengthy
 19 report on the ER/PR issue on this date?
 20 MS. JONES:
 21 A. Yes. Just to the top, what day is it?
 22 CHAYTOR, Q.C.:
 23 Q. Sorry. This is November 21st, 2006.
 24 MS. JONES:
 25 A. Okay. Just before they did the December -

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1 CHAYTOR, Q.C.:
 2 Q. Yes, just before the December briefing.
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. And Mr. Tilley welcomed Dr. Denic and his team
 7 who were there, which included Dr. Cook, Dr.
 8 Elms and also Kara Laing is present and Dan
 9 Boone is also present.
 10 MS. JONES:
 11 A. Um.
 12 CHAYTOR, Q.C.:
 13 Q. And Terry Gulliver and Heather Predham are
 14 also?
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. So they're all guests for the ER/PR
 19 presentation?
 20 MS. JONES:
 21 A. Yeah.
 22 CHAYTOR, Q.C.:
 23 Q. Do you recall this, do you recall this
 24 meeting?
 25 MS. JONES:

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1 A. I recall some of the meeting because there was
 2 a fair amount of discussion around some of the
 3 technical aspects in terms of the
 4 presentation. And I do remember us saying we
 5 probably are aware of that, let's go down
 6 through the entire presentation, what we're
 7 talking about, so going back to ER/PR, what is
 8 Tamoxifen, all of those kinds of things.
 9 CHAYTOR, Q.C.:
 10 Q. And so who--we see that Dr. Denic, obviously
 11 did some presentation and Dr. -
 12 MS. JONES:
 13 A. And Dr. Laing.
 14 CHAYTOR, Q.C.:
 15 Q. - Kara Laing?
 16 MS. JONES:
 17 A. Yes, that's right.
 18 CHAYTOR, Q.C.:
 19 Q. Did anyone else speak?
 20 MS. JONES:
 21 A. I don't remember Ford Elms speaking, but
 22 that's not to say that Ford wouldn't have. I
 23 would have expected Don Cook to have
 24 commentary, as well. And if--can you just
 25 roll down?

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1 CHAYTOR, Q.C.:

2 Q. Sure. And you have control, too, if you wish.

3 MS. JONES:

4 A. Okay.

5 CHAYTOR, Q.C.:

6 Q. To scroll down.

7 MS. JONES:

8 A. Talked about no national.

9 CHAYTOR, Q.C.:

10 Q. I see Dr. Howell's name in follow up on a few

11 items.

12 MS. JONES:

13 A. Yeah, yeah.

14 CHAYTOR, Q.C.:

15 Q. So the presentation, I take it, was by Dr.

16 Denic?

17 MS. JONES:

18 A. Yes, and Kara Laing.

19 CHAYTOR, Q.C.:

20 Q. And Kara Laing?

21 MS. JONES:

22 A. Yeah.

23 CHAYTOR, Q.C.:

24 Q. Okay.

25 MS. JONES:

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1 A. And I do remember Kara talking a fair bit

2 about epidemiology and Tamoxifen and adjunct

3 (sic.) therapy and all those kinds of things.

4 CHAYTOR, Q.C.:

5 Q. Okay. So in Dr. Denic's presentation it says

6 "Focused on the reliability of the testing."

7 MS. JONES:

8 A. Yeah.

9 CHAYTOR, Q.C.:

10 Q. "And the variables that influence the

11 results."?

12 MS. JONES:

13 A. Yes. And you have this issue of DAKO and

14 Ventana again.

15 CHAYTOR, Q.C.:

16 Q. Yes. "Discussion focused on documentation,

17 standardized procedures, semi-automatic

18 systems versus the new Ventana system."

19 MS. JONES:

20 A. Yeah.

21 CHAYTOR, Q.C.:

22 Q. So that was still discussed as an issue?

23 MS. JONES:

24 A. Absolutely.

25 CHAYTOR, Q.C.:

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1 Q. Do you recall what was the issue between the

2 semi-automatic and the new Ventana, what was

3 discussed?

4 MS. JONES:

5 A. The issue is more that with the semi-automatic

6 you would have had lots of more interaction

7 with the individual technologist, okay, in

8 preparing the slides. And they had--the

9 boiling of the tissue, we talked a lot about

10 boiling of tissue and whether, in fact, for

11 the exact period of time and those kinds of

12 things. So with moving to a more automated

13 system, it would be a more precise than was

14 with the DAKO system.

15 CHAYTOR, Q.C.:

16 Q. Okay. And "Discussion focused on

17 documentation, standardized procedures."

18 MS. JONES:

19 A. Yes.

20 CHAYTOR, Q.C.:

21 Q. And what was the focus of that?

22 MS. JONES:

23 A. I can't tell you what the exact focus of that

24 would have been.

25 CHAYTOR, Q.C.:

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1 Q. Was there anything -

2 MS. JONES:

3 A. Probably related to, you know, we carried out

4 this procedure and we carried it out, but did

5 we have the documentation to say exactly three

6 minutes, five minutes, two minutes, whatever,

7 what was the temperate of, all of those kinds

8 of things. So it was more on did we actually

9 document versus did we do it.

10 CHAYTOR, Q.C.:

11 Q. And the standardized procedures, did that

12 involve the standardized procedures in the lab

13 itself, the technologists, the pathologists,

14 who -

15 MS. JONES:

16 A. I have no--I can't speak to that.

17 CHAYTOR, Q.C.:

18 Q. Did it--was the issue of fixation mentioned?

19 MS. JONES:

20 A. Not sure.

21 CHAYTOR, Q.C.:

22 Q. Was that something you think you would recall

23 if fixation came up, given your previous

24 involvement?

25 MS. JONES:

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1 A. Not in the nature of this discussion because
 2 this was in discussion of talking about a
 3 technical briefing for the media and moving
 4 forward with that.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. So the purpose of doing this -
 7 MS. JONES:
 8 A. Was to bring executive in line with where they
 9 were.
 10 CHAYTOR, Q.C.:
 11 Q. What's going to happen at the media briefing?
 12 MS. JONES:
 13 A. That's right.
 14 CHAYTOR, Q.C.:
 15 Q. Okay. So this was to be the same presentation
 16 that would happen with the media?
 17 MS. JONES:
 18 A. That was--would have been my understanding.
 19 CHAYTOR, Q.C.:
 20 Q. That was your understanding.
 21 MS. JONES:
 22 A. It was we will have had this and so that
 23 you're aware of what would be part of that
 24 technical briefing.
 25 CHAYTOR, Q.C.:

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1 Q. Why is Dan Boone present?
 2 MS. JONES:
 3 A. I can't speak to why Dr. Howell would have
 4 wanted him present, but it could have been
 5 anything, it could have been ER/PR lawsuit,
 6 who knows.
 7 CHAYTOR, Q.C.:
 8 Q. So he would have been there at the request of
 9 Dr. Howell?
 10 MS. JONES:
 11 A. I would think.
 12 CHAYTOR, Q.C.:
 13 Q. In Dr. Denic's presentation on the variables
 14 that influenced the results and the discussion
 15 focusing on those things that we just noted,
 16 was there any discussion at all on any of the
 17 work of the pathologists?
 18 MS. JONES:
 19 A. Probably--you know, what I would have known
 20 that Dr. Denic would have talked about is the
 21 development of the breast pathology group.
 22 CHAYTOR, Q.C.:
 23 Q. Yes.
 24 MS. JONES:
 25 A. And that and I would have known that there was

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1 additional education. But whether it was
 2 inside of the context of this particular
 3 presentation, I'm not sure.
 4 CHAYTOR, Q.C.:
 5 Q. So you don't know if that was discussed here
 6 or not?
 7 MS. JONES:
 8 A. No.
 9 CHAYTOR, Q.C.:
 10 Q. And where would you have learned it otherwise?
 11 MS. JONES:
 12 A. Well, only because as we're moving forward
 13 with the recommendations and we had stopped
 14 doing this, this is a year later, that there
 15 was lots of activity going on around
 16 documentation and education.
 17 CHAYTOR, Q.C.:
 18 Q. There was lots of activity going on around
 19 documentation and education?
 20 MS. JONES:
 21 A. In terms of policies, procedures, making sure,
 22 those kinds of things, right.
 23 CHAYTOR, Q.C.:
 24 Q. Okay.
 25 MS. JONES:

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1 A. Those would have been just generic comments
 2 that would have been made.
 3 CHAYTOR, Q.C.:
 4 Q. So new policies and procedures regarding -
 5 MS. JONES:
 6 A. Were in place. We were getting almost ready
 7 at this point in time to restart up.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. I just want to back up.
 10 MS. JONES:
 11 A. Yeah.
 12 CHAYTOR, Q.C.:
 13 Q. So there were new policies and procedures
 14 brought in in terms of education?
 15 MS. JONES:
 16 A. No, no, in terms of policies and procedures
 17 for the testing.
 18 CHAYTOR, Q.C.:
 19 Q. For the testing itself?
 20 MS. JONES:
 21 A. Right.
 22 CHAYTOR, Q.C.:
 23 Q. There were new policies and procedures?
 24 MS. JONES:
 25 A. Yes. And we were -

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1 CHAYTOR, Q.C.:

2 Q. Well, we've certainly seen the fixation

3 policy, which is -

4 MS. JONES:

5 A. Yeah. And at the end of -

6 CHAYTOR, Q.C.:

7 Q. Which doesn't appear to be adopted yet.

8 MS. JONES:

9 A. Yeah.

10 CHAYTOR, Q.C.:

11 Q. But what about what other policies and

12 procedures were brought in?

13 MS. JONES:

14 A. We wouldn't have seen those in and they

15 probably would not have ever been included in

16 the detail here, only that work was done.

17 CHAYTOR, Q.C.:

18 Q. I'm sorry, the policies and procedures?

19 MS. JONES:

20 A. For the testing -

21 CHAYTOR, Q.C.:

22 Q. There were new policies and procedures brought

23 in to play in terms of how to carry out the

24 ER/PR testing?

25 MS. JONES:

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1 A. That's right.

2 CHAYTOR, Q.C.:

3 Q. Okay.

4 MS. JONES:

5 A. And that was a lot of the work that really

6 before we ever restarted that those were the

7 kinds of things that from a formalization

8 perspective, formalizing what we already did

9 or looking at best practice, right.

10 CHAYTOR, Q.C.:

11 Q. And so those new policies and procedures would

12 have been brought in then prior to this date,

13 November, 2006?

14 MS. JONES:

15 A. I'm sure they were being worked on, but I

16 can't speak to that because I wasn't involved

17 in that.

18 CHAYTOR, Q.C.:

19 Q. And would they have come through to executive

20 for you to have -

21 MS. JONES:

22 A. No.

23 CHAYTOR, Q.C.:

24 Q. - knowledge of them?

25 MS. JONES:

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1 A. No.

2 CHAYTOR, Q.C.:

3 Q. How would you have knowledge of that?

4 MS. JONES:

5 A. Only in general conversation about how close

6 we were ready to start retesting inside of

7 Eastern Health again.

8 CHAYTOR, Q.C.:

9 Q. And who would be providing you with the

10 information?

11 MS. JONES:

12 A. That would have been, at this point in time it

13 would have been Dr. Howell, because he would

14 have -

15 CHAYTOR, Q.C.:

16 Q. Through executive management?

17 MS. JONES:

18 A. Through the executive management, where we

19 were on the point.

20 CHAYTOR, Q.C.:

21 Q. And he would have told about policies and

22 procedures that have come -

23 MS. JONES:

24 A. Not specifically but just saying the

25 recommendations are--we're almost ready to

Page 384

1 restart, so those recommendations -

2 CHAYTOR, Q.C.:

3 Q. Did the executive management ever see these

4 spreadsheet of recommendations?

5 MS. JONES:

6 A. I've seen it now, but at what point in time we

7 would have seen it, I can't--I can't even

8 think about really where that would have been.

9 CHAYTOR, Q.C.:

10 Q. And then Kara Laing's presentation focused on

11 epidemiology, adjuvant therapy and metastatic,

12 sorry, cancer.

13 MS. JONES:

14 A. Yeah.

15 CHAYTOR, Q.C.:

16 Q. Hormone receptors, the evolution of endo -

17 MS. JONES:

18 A. Endocrine therapies.

19 CHAYTOR, Q.C.:

20 Q. Thank you. And impact on clinical management?

21 MS. JONES:

22 A. Um.

23 CHAYTOR, Q.C.:

24 Q. And "The tumor group, breast disease group

25 continues to review and monitor ER/PR and Her-

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1 2-neu"?

2 MS. JONES:

3 A. Um.

4 CHAYTOR, Q.C.:

5 Q. Now this is in November, 2006?

6 MS. JONES:

7 A. 2006.

8 CHAYTOR, Q.C.:

9 Q. So what ER/PR and her-2-neu would that group

10 be monitoring?

11 MS. JONES:

12 A. Well, it says here "The tumor, breast group

13 continues to review and monitor ER/PR and her-

14 2." We were not doing her-2, right.

15 CHAYTOR, Q.C.:

16 Q. Nor were you doing ER/PR -

17 MS. JONES:

18 A. ER/PR, so the results that were coming back, I

19 would expect, were being because those results

20 then were going into pathology reports that

21 were being distributed throughout the

22 organization. So this tumor, breast group was

23 a specialty group that had developed.

24 CHAYTOR, Q.C.:

25 Q. So this tumor group, breast group are

Page 386

1 monitoring, reviewing and monitoring--your

2 understanding of this was that this is the

3 retests?

4 MS. JONES:

5 A. No, but the tumor group and breast disease

6 group, there's pathologists as well as

7 oncologists.

8 CHAYTOR, Q.C.:

9 Q. Yes.

10 MS. JONES:

11 A. Coming together to look at ER/PR, her-2 and

12 the implications.

13 CHAYTOR, Q.C.:

14 Q. Okay. So it's the issue as opposed to the

15 test?

16 MS. JONES:

17 A. Issue.

18 CHAYTOR, Q.C.:

19 Q. Okay. "From all indications the level of

20 confidence from the oncologists in the

21 laboratory testing is better than it was

22 previously."

23 MS. JONES:

24 A. Um.

25 CHAYTOR, Q.C.:

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1 Q. And "The following points then were raised

2 during the presentation." First, "The

3 organization cannot speak publicly on the

4 findings and recommendations of the review

5 because there is currently a class action

6 lawsuit ongoing. This information is

7 protected under the Evidence Act. Discussion

8 ensued regarding the need to share the

9 experience with the other pathologists within

10 the province." And then "Dr. Howell and Dan

11 Boone are to discuss further to making any

12 discussion," think something wrong in that

13 sentence.

14 MS. JONES:

15 A. Yeah.

16 CHAYTOR, Q.C.:

17 Q. "Making any discussion to discuss the

18 reviewers' report with the provincial

19 pathologists."

20 MS. JONES:

21 A. "Provincial pathologists."

22 CHAYTOR, Q.C.:

23 Q. So I take it Dr. Howell and Dan Boone are

24 tasked with going away to discuss the

25 reviewers' reports, being Dr. Banerjee and

Page 388

1 Trish Wegrynowski?

2 MS. JONES:

3 A. Yes.

4 CHAYTOR, Q.C.:

5 Q. And so they're going away to discuss further

6 prior to any disclosure of that information to

7 the other pathologists?

8 MS. JONES:

9 A. That's right.

10 CHAYTOR, Q.C.:

11 Q. Is that right?

12 MS. JONES:

13 A. Yes, that's what that looks like it appears to

14 reflect.

15 CHAYTOR, Q.C.:

16 Q. So what does "The organization cannot speak

17 publicly on the findings and recommendations

18 because there is currently a class action

19 lawsuit going on."?

20 MS. JONES:

21 A. I would take that more to be the findings and

22 recommendations because the information is

23 protected under the Evidence Act. I'm not

24 sure whether that was captured the way it was

25 said. And if you go on further, it says that

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1 "Dr. Howell and Boone will discuss if there's
 2 any way of making those recommendations
 3 available," because we would have had
 4 pathologists throughout the entire province at
 5 the point in time when we started back testing
 6 or doing the technical aspect of the ER/PR
 7 needing to understand what had happened, if
 8 that was possible, to be able to explain it to
 9 them so that they would then come back to
 10 start using the slides. So there had to be
 11 confidence in the system around that.

12 CHAYTOR, Q.C.:
 13 Q. Oh, absolutely. And do I understand from this
 14 that the information of the reviewers, Dr.
 15 Banerjee and Trish Wegrynowski, as to any
 16 issues that needed to be addressed, that had
 17 not been shared with the other pathologists in
 18 the province up to this point in time?

19 MS. JONES:
 20 A. I would think that you're right on that
 21 assumption.

22 CHAYTOR, Q.C.:
 23 Q. And this is over a year later?

24 MS. JONES:
 25 A. That's right. Because there's no testing

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1 going on at this point in time. All of the
 2 tests are being sent out of the province. And
 3 at the point in time when we needed to--when
 4 we were ready to restart testing inside of
 5 Eastern Health, then there would need to be
 6 assurance given to the province that that
 7 testing was, you know, best practice.

8 CHAYTOR, Q.C.:
 9 Q. There's no testing going on in St. John's, but
 10 obviously everybody's sending their samples to
 11 Mount Sinai -

12 MS. JONES:
 13 A. Yes.

14 CHAYTOR, Q.C.:
 15 Q. - or wherever to be tested. What about the
 16 fixation issue? I mean, fixation is still an
 17 issue and that's still happening in all the
 18 centres across the province. Have that issue
 19 been communicated?

20 MS. JONES:
 21 A. That issue, I think you will see
 22 correspondence from Dr. Cook, which would have
 23 been original, that would have been talking

Page 391

1 about fixation in the earlier fashion.
 2 CHAYTOR, Q.C.:
 3 Q. So the finding regarding fixation had been
 4 communicated by Dr. Cook to the other
 5 pathologists?

6 MS. JONES:
 7 A. Well, it was inside of Eastern Health, right,
 8 so really Dr. Cook will have to determine that
 9 and those particular tests were being read by
 10 Mount Sinai, so whether there was
 11 correspondence from Mount Sinai to the
 12 individual referring organization or not, I'm
 13 not sure. But there is at least a couple of
 14 occasions where fixation in the history of
 15 this issue has been talked about with the
 16 other regional health authorities.

17 CHAYTOR, Q.C.:
 18 Q. Okay, and is that prior to this date, November
 19 of 2006?

20 MS. JONES:
 21 A. Oh yes, yeah.

22 CHAYTOR, Q.C.:
 23 Q. So they were made aware of the issue?

24 MS. JONES:
 25 A. Yeah, and I only know that because in

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1 reviewing all of the documents, you would see
 2 some of the level, not related to the 2005,
 3 not related here to 2005 that fixation is an
 4 issue.

5 CHAYTOR, Q.C.:
 6 Q. So in reviewing the documents, you're aware
 7 that there was communication or there are
 8 documentation--there's documentation to show
 9 that Dr. Cook communicated the fixation issue
 10 with the other regions?

11 MS. JONES:
 12 A. No, I said I am aware -

13 CHAYTOR, Q.C.:
 14 Q. Internally within Eastern Health.

15 MS. JONES:
 16 A. Internally within Eastern Health, and there
 17 are other--there is other documentation by
 18 other pathologists earlier, prior to 2005,
 19 that talks about fixation.

20 CHAYTOR, Q.C.:
 21 Q. Okay, I want to be clear on that.

22 COFFEY, Q.C.:
 23 Q. Ejeckam.

24 CHAYTOR, Q.C.:
 25 Q. That's Dr. Ejeckam you mean?

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1 MS. JONES:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. In 2003.
 5 MS. JONES:
 6 A. Yes, and earlier than that.
 7 CHAYTOR, Q.C.:
 8 Q. And earlier again?
 9 MS. JONES:
 10 A. I'm thinking that there was something earlier
 11 as well.
 12 CHAYTOR, Q.C.:
 13 Q. Even before Dr. Ejeckam -
 14 MS. JONES:
 15 A. Yeah.
 16 CHAYTOR, Q.C.:
 17 Q. - identifying fixation as an issue?
 18 MS. JONES:
 19 A. Well, fixation in 2003, but you will have
 20 documents that -
 21 CHAYTOR, Q.C.:
 22 Q. We do have, certainly, Dr. Ejeckam's and we do
 23 have some documentation from Dr. Khalifa.
 24 Would that be what you're thinking of?
 25 MS. JONES:

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1 A. I'm thinking, yes, those were the two that I
 2 would remember.
 3 CHAYTOR, Q.C.:
 4 Q. Okay, which is -
 5 MS. JONES:
 6 A. But I wouldn't have known that only from going
 7 back through the documents as in this role.
 8 CHAYTOR, Q.C.:
 9 Q. But in terms of it remaining an issue in 2005
 10 when Dr. Banerjee and Trish Wegrynowski are
 11 into Eastern Health, and anything Dr. Banerjee
 12 and Trish Wegrynowski may have identified in
 13 terms of the fixation issue, up to this point
 14 in time, November 2006, to your knowledge had
 15 that been conveyed to the other pathologists?
 16 MS. JONES:
 17 A. You'll have to ask Dr. Cook on that one, or
 18 even Dr.--in November 2006, it could have been
 19 Williams or Howell who would have been dealing
 20 with the others.
 21 CHAYTOR, Q.C.:
 22 Q. And because the discussion at this point is
 23 regarding the need to share the experience
 24 with the other pathologists within the
 25 province?

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1 MS. JONES:
 2 A. Which is--yeah.
 3 CHAYTOR, Q.C.:
 4 Q. Yes, okay, and for patient safety, that would
 5 be a good thing. Okay, "there is no national
 6 laboratory accreditation process for
 7 immunohistochemical laboratories. Ontario and
 8 the western provinces have provincial
 9 accreditation programs. However, the Atlantic
 10 Provinces do not. Prior to 1995, the
 11 laboratory was accredited under the broad
 12 blanket of CCHSA accreditation. Participation
 13 in an accreditation program is a high priority
 14 on all levels and Dr. Howell is to inquire
 15 further."
 16 MS. JONES:
 17 A. Yes.
 18 CHAYTOR, Q.C.:
 19 Q. So the laboratory was accredited prior to
 20 1995?
 21 MS. JONES:
 22 A. I can't answer that question, but we did never
 23 have lab accreditation in this province like
 24 you would see in some of the other provinces.
 25 Canadian Council of Health Service

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1 accreditation would have had a lab in a
 2 generic sense, in terms of a lab team and
 3 probably been accredited, just like diagnostic
 4 imaging, but really you would have to go back
 5 to the standards for accreditation for the
 6 Canadian Council of Health Services
 7 accreditation to look at the depth of that.
 8 CHAYTOR, Q.C.:
 9 Q. Now I've seen in the documentation where you
 10 have been responsible for accreditation at
 11 different points in time, where you have been
 12 one of the leaders involved.
 13 MS. JONES:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. But you don't know anything about the lab
 17 being accredited prior to 1995?
 18 MS. JONES:
 19 A. No. No, and it would not have been
 20 accredited--it would only have been accredited
 21 if in fact there was CCHSA had specific
 22 standards for lab pre-1995, that it would have
 23 been accredited just like surgery program or
 24 just like any other part of the hospital
 25 system, and I am an accreditor with Canadian

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1 Council of Health Services Accreditation since
 2 1990, but the level of direct discipline
 3 specific accreditation would not be inside of
 4 Canadian Council of Health Service
 5 Accreditation. You really need to go to
 6 specialty accreditation for that.
 7 CHAYTOR, Q.C.:
 8 Q. Okay, and I will address with you the
 9 accreditation which ultimately happens a year
 10 later.
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. Or thereabouts. Bullet number one, what was
 15 the outcome of that issue?
 16 MS. JONES:
 17 A. Bullet number one, which -
 18 CHAYTOR, Q.C.:
 19 Q. Bullet number one, Dr. Howell and Dan Boone
 20 were going away to further discuss prior to
 21 release or prior to the information from the
 22 reviewer's report being given to the other
 23 pathologists.
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:
 2 Q. What happened to that issue?
 3 MS. JONES:
 4 A. I have no idea what would have happened with
 5 that.
 6 CHAYTOR, Q.C.:
 7 Q. Okay. Ms. Jones, the briefing on this day and
 8 the issue of the other pathologists in the
 9 other areas of the province not having certain
 10 information, did that cause you any concern?
 11 MS. JONES:
 12 A. I think that what--we clearly were not doing
 13 ER/PR testing at the time, so that would have
 14 been all of samples inside of this province
 15 were being sent to Mount Sinai. So at that
 16 point in time, I guess that would not have
 17 registered because there was nothing happening
 18 in this province, that we were actually
 19 referring out to a best practice lab.
 20 CHAYTOR, Q.C.:
 21 Q. So implicit in that is that prior to Eastern
 22 Health starting or commencing to do the
 23 testing again in February 2007, there would
 24 have to be the dissemination of knowledge to
 25 the other pathologists?

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1 MS. JONES:
 2 A. We would have had to have some discussion with
 3 them to have assurance that our lab was
 4 producing reliable results and that they would
 5 have confidence in sending their samples to
 6 Eastern Health, yes.
 7 CHAYTOR, Q.C.:
 8 Q. Now you had been involved in the fixation
 9 issue back early on in September 2005. The
 10 fixation issue was brought to your attention.
 11 MS. JONES:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. Were you concerned, in November 2006, bearing
 15 in mind that you're aware there was a fixation
 16 issue, were you concerned then that
 17 pathologists outside of the region may or may
 18 not know this?
 19 MS. JONES:
 20 A. Wouldn't have entered my mind because my
 21 responsibility was inside of Eastern Health
 22 and we had addressed that issue there in
 23 working through the issues that we had. So in
 24 terms of a provincial role or whether in fact
 25 I would have had a screen or a lenses that

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1 says "did this go outside?" that never entered
 2 my mind.
 3 CHAYTOR, Q.C.:
 4 Q. So in terms of the responsibility for people
 5 outside of--patients outside of Eastern
 6 Health, you didn't connect this?
 7 MS. JONES:
 8 A. No, that was not anything that I would have
 9 talked about or thought about at the time.
 10 CHAYTOR, Q.C.:
 11 Q. What about the idea of--this whole idea, and
 12 of course, we spent a couple of days last week
 13 talking about patient safety issues and, you
 14 know, disclosure issues. What about this
 15 whole concept of not sharing information from
 16 which there can be learnings, because there's
 17 some protection, legal protection to the
 18 information? Does that concern you?
 19 MS. JONES:
 20 A. No, that never ever concerned me, and I think
 21 if you look at the accreditation report in
 22 2004 that Health Care Corp had, there's a
 23 reference in the accreditation report about us
 24 sharing issues and being one of the
 25 provincial--you know, one of the individuals

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1 or partners in the province that would share
 2 information for the betterment of the
 3 province. So that's actually recognized in a
 4 good practice in 2004.
 5 CHAYTOR, Q.C.:
 6 Q. So in terms of sharing information, so what
 7 you're saying is Eastern Health or the Health
 8 Care Corporation then erred on the side of
 9 providing information?
 10 MS. JONES:
 11 A. Well, there was a--there's a group
 12 provincially called--whether it's quality
 13 people, I'm not sure what the name would have
 14 been, but it would have been the quality
 15 people that had a working group and they would
 16 have shared information inside of that group
 17 around issues that they may have been exposed
 18 to or where there were best practices or those
 19 kinds of things. So there was a provincial
 20 group prior to restructuring in 2005 where
 21 there was a group of risk managers, quality
 22 leaders, whatever way it was couched at the
 23 time, underneath probably the Newfoundland and
 24 Labrador Health Board's Association where that
 25 sharing did take place.

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1 CHAYTOR, Q.C.:
 2 Q. And does that--and so you're saying that you
 3 weren't concerned because you're assuming that
 4 communication was taking place at that level?
 5 MS. JONES:
 6 A. No, I'm not. I'm just saying that we were
 7 acknowledged in 2004 to be one of the leaders
 8 in ensuring that where there were issues in
 9 terms of that vehicle, that information was
 10 shared across in the province.
 11 CHAYTOR, Q.C.:
 12 Q. Yes, and was that continuing then in 2005 and
 13 2006?
 14 MS. JONES:
 15 A. It did pick up again, but it may be in the
 16 restructuring, as new individuals were put in
 17 place inside of the new four regional health
 18 authorities, but that definitely is in place
 19 again at this point in time. How far back,
 20 you know, a year or absolutely more than that,
 21 it has been. So there was a period of time
 22 with the restructuring that that group did not
 23 meet, but it continues to meet now.
 24 CHAYTOR, Q.C.:
 25 Q. So you weren't concerned in 2004 because it

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1 seems that the organization was doing it
 2 right.
 3 MS. JONES:
 4 A. Yes.
 5 CHAYTOR, Q.C.:
 6 Q. And putting the issues of sharing of best
 7 practices in the forefront.
 8 MS. JONES:
 9 A. Yes.
 10 CHAYTOR, Q.C.:
 11 Q. And was that being done, notwithstanding any
 12 issue of privilege or protection to the
 13 information?
 14 MS. JONES:
 15 A. I think that when you talk about that, I'm not
 16 sure where that is, but there is always
 17 sharings that come out, and that they move
 18 forward. So there was no lens of legal, let's
 19 put it that way, that was put up there.
 20 CHAYTOR, Q.C.:
 21 Q. Yes, which is what I'm, you know, reading in
 22 this bullet, rightly or wrongly.
 23 MS. JONES:
 24 A. This is Evidence Act.
 25 THE COMMISSIONER:

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1 Q. But are you saying that in spite of the
 2 Evidence Act, the information regarding what
 3 was happening in your lab would go to other
 4 labs?
 5 MS. JONES:
 6 A. General information would be shared.
 7 THE COMMISSIONER:
 8 Q. Well, what's general information as opposed to
 9 specific information?
 10 MS. JONES:
 11 A. Well, the issue around best practice.
 12 THE COMMISSIONER:
 13 Q. For example, fixation.
 14 MS. JONES:
 15 A. Issues around best practice, they don't
 16 necessarily have -
 17 THE COMMISSIONER:
 18 Q. Well, does that mean they would get the
 19 information regarding the problems with
 20 fixation, for example?
 21 MS. JONES:
 22 A. I can't speak to that particular one, but if
 23 you look at the literature in best practice
 24 and those kinds of things, that these groups
 25 would be coming together. The lab directors

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1 across the province would be meeting fairly
 2 regularly and those kinds of issues would be
 3 discussed.
 4 THE COMMISSIONER:
 5 Q. Well, can I conclude then, and just in terms
 6 of--because frankly, it bothers me a great
 7 deal and it came out in part of last week's,
 8 and that is the apparent conflict between the
 9 idea that patient safety demands that
 10 information be shared, not only patient safety
 11 within the institution in which the issue
 12 arises, but patient safety in other
 13 institutions. If this whole process has
 14 taught me anything, as I've been looking at
 15 the reports from around the world, it's how
 16 often the same problems keep occurring over
 17 and over and over and over again, and you got
 18 to say to yourself, doesn't anybody talk to
 19 anybody.
 20 MS. JONES:
 21 A. Yes.
 22 THE COMMISSIONER:
 23 Q. Now I mean prima facie, one of the problems is
 24 you have a system which says information shall
 25 not be shared, based on a legal system which

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1 has been in existence for a long period of
 2 time, but basically that says keep it to your
 3 vest, don't let it out, and you have a patient
 4 safety movement which says if we're going to
 5 get anywhere, we have to be transparent, which
 6 I take to mean you have to get information out
 7 there. Now if that information is going to be
 8 useful to other institutions, and I think here
 9 particularly of institutions who rely on
 10 Eastern Health for their testing, then I've
 11 got a real problem with how you can properly
 12 do that if you're not going to tell them the
 13 information that is in the two reports.
 14 Now there are, I'm sure, ways around
 15 everything, but the question that then comes
 16 to my mind is if, in conversations, not
 17 recorded, in general discussions about
 18 laboratory safe practices, all of the
 19 information in Dr. Banerjee's report, for
 20 example, were conveyed to people around the
 21 rest of the province, those of you in the
 22 health industry might say "well, that's good
 23 because we've gotten all that information out
 24 there," but it seems then that the only people
 25 who don't know what was in the report are the

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1 people whose test results changed, and my
 2 question then becomes is that right either? So
 3 I really, really would be interested in
 4 knowing whether or not, in spite of the
 5 Evidence Act, in spite of the fact that these
 6 reports are four copies which don't go
 7 anywhere, except to four, perhaps five
 8 individuals within institution, all that
 9 information gets out there.
 10 MS. JONES:
 11 A. And I think that what you would need to
 12 understand in the way that we work is the
 13 actual report is protected and that in
 14 discussions around various issues that in fact
 15 best practice, we do talk about best practice,
 16 and what should be done in the various groups,
 17 that in this province there is a mandatory
 18 reporting, like there are in some of the
 19 provinces, around occurrence reporting that
 20 then goes forward, but vehicles such as the
 21 quality and safety leaders that come together
 22 on a provincial basis do share across those
 23 vehicles and in vehicles such as, just exactly
 24 like you have said, in terms of the VPs of
 25 medicine or those responsible for lab come

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1 together and there is discussion in those
 2 vehicles around our learnings.
 3 Your comment about whether in fact, you
 4 know, it goes to the public, I really have--I
 5 can't answer that particular comment, but
 6 there's sharing of learnings.
 7 THE COMMISSIONER:
 8 Q. Well, it just seems to me it's an argument
 9 about having your cake and eating it too, in
 10 the sense of if this is truly privileged,
 11 based on a logic which in its infancy was
 12 designed for patient safety actually, then
 13 what I'm hearing, and perhaps I'd better tell
 14 you what I'm hearing because you may tell me
 15 that I'm wrong because what I'm hearing is
 16 that yes, on the one hand, we're keeping it
 17 privileged and close to our vest, but wink,
 18 wink, nod, nod, we tell everybody what's in
 19 it, in our way, because we don't say "Dr.
 20 Banerjee told us to do this." We say, "we now
 21 have, as a result of some external reviews,"
 22 we might not even put it that way, but "we now
 23 have developed best practices which we have
 24 now established for our labs and we do want to
 25 share our best practice with you, which we

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1 have developed perhaps with the assistance of
 2 people who have come from outside, like
 3 British Columbia."
 4 So in effect, you're telling everybody
 5 what Dr. Banerjee told you to do in your lab,
 6 but you're saying to somebody who might want
 7 to have access to that, "sorry, that's covered
 8 by the Evidence Act and we can't let you have
 9 it."
 10 MS. JONES:
 11 A. And I think that that's fair to say that, in
 12 terms of the way that you just explained it,
 13 and I think that at the end of the day, that
 14 does move the issue forward. You ask the
 15 question around the public, at this instance,
 16 when we talk about all of the recommendations
 17 that we would have put in place and trying to
 18 identify what the actual causal relationship
 19 on this particular test on that particular
 20 day, I don't know whether we will be able to,
 21 and that is really for, you know, others who
 22 know much more about this issue than me, but
 23 really all of this issue about policies,
 24 procedures, quality assurance, accreditation,
 25 education, best practice, that's a way of

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1 ensuring, in the future, that this doesn't
 2 happen again. So we create redundancies in
 3 the system, so that if there is an issue, the
 4 redundancy is always picked up and that's the
 5 discussion that we have all the time, around
 6 how can we make the system the best that we
 7 possibly can make it and create redundancy so
 8 that there is not an issue into the future,
 9 and that's our sharing that we would have with
 10 everybody else.
 11 THE COMMISSIONER:
 12 Q. So back to Ms. Chaytor's point, so wasn't
 13 fixation pretty critical for your colleagues
 14 across the province who were dealing with
 15 Eastern Health, who might not at that moment
 16 have been, but unless Mount Sinai talked to
 17 them about what they were doing in fixation,
 18 would have been carrying on as usual. Now I'm
 19 making an assumption. Perhaps their
 20 procedures were different than Eastern
 21 Health's and perhaps there was no problem with
 22 fixation outside of Eastern Health, I don't
 23 know that, but assuming for the moment that
 24 they had similar problems to those which were
 25 discovered within Eastern Health, then aren't

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1 we dooming them to repeat the errors while we,
 2 at Eastern Health, are carrying on?
 3 MS. JONES:
 4 A. And I think that you would really need to ask
 5 Dr. Williams, as well as Dr. Howell, what
 6 discussions they had with other lab directors
 7 or the people who were responsible for the lab
 8 and what actually did go out there in
 9 communication, because there were
 10 communication issues around fixation in 2003,
 11 and I only know that after the fact, but -
 12 CHAYTOR, Q.C.:
 13 Q. Dr. Ejeckam.
 14 MS. JONES:
 15 A. Yes, right, and so -
 16 THE COMMISSIONER:
 17 Q. Well, that didn't seem--well, I don't know,
 18 perhaps--so are you suggesting that Dr.
 19 Ejeckam's particular memo solved the fixation
 20 problems within Eastern Health?
 21 MS. JONES:
 22 A. No, I'm suggesting that that particular memo
 23 heightened and at least made people aware that
 24 there was a fixation issue.
 25 THE COMMISSIONER:

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1 Q. Okay.
 2 MS. JONES:
 3 A. And that to pay attention to it. Did these -
 4 THE COMMISSIONER:
 5 Q. So if there were conversations of the informal
 6 kind about fixation, it would be Dr. Howell or
 7 Dr. Williams who would be expected to be
 8 involved in them?
 9 MS. JONES:
 10 A. It would, absolutely, from moving that issue
 11 forward with their counterparts.
 12 THE COMMISSIONER:
 13 Q. Okay, and what about the people in the
 14 laboratory, Dr. Cook or someone of that
 15 nature? Would he be expected to be involved
 16 in that kind of conversation?
 17 MS. JONES:
 18 A. I would think that Don Cook would have or the
 19 clinical chiefs that were in there, or at
 20 least in Dr. Ejeckam's time, it was the
 21 divisional chief responsible for.
 22 THE COMMISSIONER:
 23 Q. Okay, thank you. That's helpful.
 24 CHAYTOR, Q.C.:
 25 Q. Thank you. And then this bullet says

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1 "discussion ensued regarding the need to share
 2 the information," Ms. Jones, "with the other
 3 pathologists within the province." Dr. Howell
 4 is present and Dr. Howell is tasked with
 5 discussing this issue further with the
 6 solicitor.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. So I take it if that had happened and the
 11 information had already been conveyed, there
 12 would be no need for Dr. Howell and Dan Boone
 13 to be discussing the issue further.
 14 MS. JONES:
 15 A. I can't make a comment on that. This here
 16 just reflects that they would discuss that
 17 outside of this particular presentation.
 18 CHAYTOR, Q.C.:
 19 Q. Who's bringing up the issue? Who's saying
 20 discussion ensued? Obviously somebody is
 21 concerned about getting this information out
 22 to the other pathologists. Do you recall who
 23 was concerned about this?
 24 MS. JONES:
 25 A. No, I don't.

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1 CHAYTOR, Q.C.:
 2 Q. Okay. And if Dr. Howell and Dr. Williams are
 3 the ones who would have conveyed the
 4 information, it appears that Dr. Howell is not
 5 aware of it.
 6 MS. JONES:
 7 A. And it may very well have been conveyed by Dr.
 8 Williams because he was there through the
 9 entire first year and maybe Oscar doesn't know
 10 the technical part of whether, in fact, Dr.
 11 Williams had already addressed that issue.
 12 CHAYTOR, Q.C.:
 13 Q. So, we're down to Dr. Williams, if it were
 14 conveyed?
 15 MS. JONES:
 16 A. Originally, and if it wasn't, then Dr. Howell
 17 would have been moving that forward.
 18 CHAYTOR, Q.C.:
 19 Q. Well, I would think Dr. Howell would jump into
 20 the fray here and say that, well, no, that's
 21 already been taken care of.
 22 MS. JONES:
 23 A. But he may not have known that -
 24 CHAYTOR, Q.C.:
 25 Q. If Dr. Howell had taken care of it.

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1 MS. JONES:
 2 A. That's right.
 3 CHAYTOR, Q.C.:
 4 Q. So, we're down to Dr. Williams?
 5 MS. JONES:
 6 A. (No audible response).
 7 CHAYTOR, Q.C.:
 8 Q. Correct?
 9 MS. JONES:
 10 A. You'll have to ask Dr. Williams and Dr. Howell
 11 on that.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. If I could continue on then with this--
 14 still back at the November 21, 2006 meeting.
 15 The third bullet, "the following points raised
 16 during the presentation"--the third bullet--
 17 "we have to position ourselves appropriately
 18 so that the public has confidence in the
 19 laboratory and that the people who have been
 20 waiting for information to have confidence and
 21 understanding of the events"--and I'm just
 22 reading it as it's written--"confidence in
 23 understanding of the events related to ER/PR
 24 testing. A subgroup will be established to
 25 identify key messages to be delivered and

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1 develop a strategic communication plan".
 2 So, what was the concern here in terms of
 3 and did that subgroup actually come together?
 4 MS. JONES:
 5 A. I have no idea. I'm assuming you've got Dr.
 6 Howell in conjunction with Susan Bonnell to
 7 lead that subgroup. And there was a
 8 communication that happened in December. So,
 9 I would assume that that particular issue did
 10 be addressed in that forum.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So, that's the media briefing, December
 13 2006.
 14 MS. JONES:
 15 A. And what messages were to be inside of that.
 16 CHAYTOR, Q.C.:
 17 Q. That's what this is about?
 18 MS. JONES:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. So, in terms of any information then that was
 22 conveyed, to allow the public to have
 23 confidence in the laboratory and an
 24 understanding of the events related to this
 25 issue, it would have been what was conveyed in

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1 the December 2006 media briefing?
 2 MS. JONES:
 3 A. Obviously that's what that would be moving
 4 towards.
 5 CHAYTOR, Q.C.:
 6 Q. Okay. And then the next bullet refers to the
 7 fact that there are currently vacancies in
 8 pathologist -
 9 MS. JONES:
 10 A. Yes.
 11 CHAYTOR, Q.C.:
 12 Q. And that Dr. Howell has efforts underway to
 13 recruit those positions?
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. The next bullet is "the organization needs to
 18 establish a date when it will return to
 19 "testing mode" and executive to agreed to
 20 extend ER/PR testing at Mount Sinai for
 21 another month". So, did that require the
 22 approval of the executive?
 23 MS. JONES:
 24 A. I think that the discussion was on--it
 25 wouldn't have required the approval of

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1 executive. There was discussion about at what
 2 point in time would we bring ER/PR testing
 3 back into our lab. And obviously, as you can
 4 see from this, there was parallel testing
 5 going on for a period of time and they were
 6 happy with the results of the parallel
 7 testing. The second or third bullet ahead of
 8 that talked about that. So -
 9 CHAYTOR, Q.C.:
 10 Q. So--sorry, didn't mean to cut you off.
 11 MS. JONES:
 12 A. So, there was always this discussion about at
 13 what point in time do we start retesting back
 14 in St. John's.
 15 CHAYTOR, Q.C.:
 16 Q. Yes. And this required the confidence of the
 17 oncologists and the medical staff?
 18 MS. JONES:
 19 A. And the medical staff and the discussion with
 20 MAC, locally.
 21 CHAYTOR, Q.C.:
 22 Q. And this says that the Medical Advisory
 23 Committee is a key group that confidence will
 24 need to be restored.
 25 MS. JONES:

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1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. So, I take it, were you hearing that the
 4 oncologists and medical staff had lost
 5 confidence in the laboratory?
 6 MS. JONES:
 7 A. I'm not sure that that would be what I would
 8 say from that. I think the next sentence is,
 9 "MAC has a major role in quality".
 10 CHAYTOR, Q.C.:
 11 Q. Yes.
 12 MS. JONES:
 13 A. And they would have wanted to be assured that
 14 we had a quality service that the parallel
 15 testing was going along well and that, in
 16 fact, that that service then was at a standard
 17 that could be restarted.
 18 CHAYTOR, Q.C.:
 19 Q. Okay. So, you weren't hearing from, for
 20 example, Dr. Kara Laing as the oncologist
 21 present at this meeting, are you hearing any
 22 issue regarding lack of confidence in the
 23 laboratory?
 24 MS. JONES:
 25 A. No, and what you would have been hearing is,

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1 is that only when we are comfortable with
 2 moving forward to restart that test, would we
 3 have done it and MAC would have probably said
 4 something like that. At the point in time
 5 when we have confidence in the system, talk to
 6 us and tell us what you're going to do.
 7 CHAYTOR, Q.C.:
 8 Q. So, obviously, that point hadn't been reached
 9 at this point because the executive is
 10 agreeing to extend the time at which Mount
 11 Sinai is going to do the testing?
 12 MS. JONES:
 13 A. Into the new year.
 14 CHAYTOR, Q.C.:
 15 Q. Into the new year. And this issue that MAC,
 16 Medical Advisory Committee, has a major
 17 quality role -
 18 MS. JONES:
 19 A. Yes.
 20 CHAYTOR, Q.C.:
 21 Q. - and a direct line or reporting to the board.
 22 MS. JONES:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. What does that mean that they have a major

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1 quality role?
 2 MS. JONES:
 3 A. That the quality of the medical staff, they
 4 report directly on the quality of care and the
 5 work that the medical staff do. And they
 6 report independently through to the board.
 7 All their credentials are approved at board as
 8 well as they do provide quality reports. They
 9 inform the board or advisory to the board on
 10 any issues that they see going on.
 11 CHAYTOR, Q.C.:
 12 Q. And did MAC, the Medical Advisory Committee,
 13 then perform a major quality role in dealing
 14 with the ER/PR issue?
 15 MS. JONES:
 16 A. I wouldn't think that they did. I think that
 17 the issue would have been brought by Dr. Cook
 18 at the time through to to say that probably
 19 we've stopped testing and we're investigating
 20 something. So, really, that you have the
 21 physicians in the area involved. And I'm sure
 22 at some point in time, the MAC minutes, there
 23 would have been discussion around ER/PR.
 24 CHAYTOR, Q.C.:
 25 Q. And what's the significance of saying that

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1 they have a direct line for reporting to the
 2 board?
 3 MS. JONES:
 4 A. Because their line for reporting is into the
 5 board. They've always had that.
 6 CHAYTOR, Q.C.:
 7 Q. In context of this issue, in talking about
 8 bringing the ER/PR testing back on stream,
 9 what's MAC's role in that?
 10 MS. JONES:
 11 A. It would be the individual discipline. It
 12 would have been Don Cook at the time or Nash
 13 Denic who--I'm not sure what point in time--
 14 making a recommendation through to Oscar
 15 Howell around that technical test piece about
 16 moving forward. If we talk about quality
 17 issues going to the board, they go through the
 18 CEO for all parts of the organization's
 19 quality issues with respect to physicians, in
 20 that respect generally come up through the
 21 MAC.
 22 CHAYTOR, Q.C.:
 23 Q. Did it involve MAC having to look at the
 24 credentialing of any of the physicians?
 25 MS. JONES:

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1 A. Not that I'm aware of, I don't believe.
 2 CHAYTOR, Q.C.:
 3 Q. And in terms of any ongoing education piece
 4 for the physicians.
 5 MS. JONES:
 6 A. No, they wouldn't have had that, as well.
 7 CHAYTOR, Q.C.:
 8 Q. Okay.
 9 MS. JONES:
 10 A. They were concerned--if you see the one above
 11 it--around the vacancies. There had been
 12 discussion around vacancies inside of MAC.
 13 CHAYTOR, Q.C.:
 14 Q. Yes, but this is a different point -
 15 MS. JONES:
 16 A. Yeah, this is a different point.
 17 CHAYTOR, Q.C.:
 18 Q. - being made here, clearly a different point.
 19 MS. JONES:
 20 A. Absolutely.
 21 CHAYTOR, Q.C.:
 22 Q. This is about the getting in testing mode and
 23 having the confidence of the physicians.
 24 MS. JONES:
 25 A. But my response there was MAC does get

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1 involved in lots of issues. We would have
 2 heard a lot about the pathology issues and
 3 recruitment and retention; not sure to the
 4 extent about ER/PR as an agenda item, except
 5 in the report that Dr. Cook or Nash Denic
 6 would have been bringing forward as their
 7 quality report through to the MAC.
 8 CHAYTOR, Q.C.:
 9 Q. Okay. Because my issue is their role in
 10 quality and their role, the significance in
 11 reporting directly to the board. So, the
 12 quality report from MAC would go directly to
 13 the board?
 14 MS. JONES:
 15 A. That's right.
 16 CHAYTOR, Q.C.:
 17 Q. So, any issue regarding ER/PR, we would expect
 18 to see in that report?
 19 MS. JONES:
 20 A. Yes, if it was on--from a physician side. The
 21 technical side would have been in other -
 22 CHAYTOR, Q.C.:
 23 Q. Right, anything regarding the physicians we
 24 would expect to see in the report that goes
 25 directly to the board.

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1 MS. JONES:
 2 A. Absolutely.
 3 CHAYTOR, Q.C.:
 4 Q. If it's there?
 5 MS. JONES:
 6 A. If it's there.
 7 CHAYTOR, Q.C.:
 8 Q. And the next bullet is "quality and risk
 9 management are confident that the appropriate
 10 processes are in place. Heather Predham
 11 advised that there are some recommendations
 12 from the review that have yet to be
 13 implemented". So this is November 21, 2006?
 14 MS. JONES:
 15 A. Yes.
 16 CHAYTOR, Q.C.:
 17 Q. And there's still some recommendations not
 18 implemented. "It's important to ensure that
 19 quality assurance monitoring processes are in
 20 place and can be sustained and monitored into
 21 the future. Documentation is of paramount
 22 importance and must be monitored and
 23 reviewed".
 24 MS. JONES:
 25 A. Yes.

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1 CHAYTOR, Q.C.:
 2 Q. And then "the director and clinical chief are
 3 directly accountable for the laboratory". And
 4 Dr. Howell is agreeing to develop a proposal
 5 regarding the leadership component for further
 6 discussion.
 7 MS. JONES:
 8 A. Yes.
 9 CHAYTOR, Q.C.:
 10 Q. What does that mean for the director and
 11 clinical chief being directly accountable for
 12 the laboratory?
 13 MS. JONES:
 14 A. The director on the technical side and the
 15 clinical chief on the physician side. And Dr.
 16 Howell did come forward with a proposal at a
 17 later date to look at a single leadership
 18 stream accountable for both the technical as
 19 well as the physician side of the
 20 organization. So, a single point.
 21 CHAYTOR, Q.C.:
 22 Q. And I'm sorry, what was the recommendation?
 23 MS. JONES:
 24 A. The recommendation is that we would have the
 25 clinical chief--no, the new role that Nash

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1 Denic is playing -
 2 CHAYTOR, Q.C.:
 3 Q. Yes.
 4 MS. JONES:
 5 A. - is the director of laboratory or clinical
 6 chief for laboratory. So, he has people who
 7 work with him, but he's overall responsible
 8 for the overall quality inside of the
 9 laboratory.
 10 CHAYTOR, Q.C.:
 11 Q. So, the role that Terry Gulliver was playing
 12 as program director, that role no longer
 13 exists in terms of the reporting structure.
 14 Now, it's Dr. Denic, is that right?
 15 MS. JONES:
 16 A. Dr. Denic is responsible for the overall that
 17 the program director, Terry Gulliver, is still
 18 there, as well as the managers and all of
 19 that. This was one of the recommendations
 20 that came out of the report, was to look at a
 21 single leadership, single individual as the
 22 ultimate point person for the quality inside
 23 of the lab. And that's what we've ultimately
 24 done with naming Dr. Denic in that role.
 25 CHAYTOR, Q.C.:

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1 Q. And that's in place now?
 2 MS. JONES:
 3 A. That's in place now.
 4 CHAYTOR, Q.C.:
 5 Q. And when did that come to be?
 6 MS. JONES:
 7 A. We had been working on it through the fall of
 8 this year and actually named in the
 9 January/February, although the--it was
 10 released in about February of this year. But
 11 in fact, there had been discussions through
 12 the fall about not so much inside of the St.
 13 John's labs about how that would be a regional
 14 position versus just the lab position in St.
 15 John's. So, that was the discussion.
 16 CHAYTOR, Q.C.:
 17 Q. So, it's as of February 2008 that it's
 18 formally in place.
 19 MS. JONES:
 20 A. And it's a regional position.
 21 CHAYTOR, Q.C.:
 22 Q. And it's regional.
 23 MS. JONES:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

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1 Q. So, all the lab managers or program directors
 2 throughout the region all report up through to
 3 Dr. Denic?
 4 MS. JONES:
 5 A. Ultimately you have all of them from a
 6 technical side reporting into Terry Gulliver
 7 and then you have Nash Denic having the
 8 pathologists report into him. And then Nash
 9 having Terry report in that fashion.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. And then ultimately Dr. Denic reports
 12 to Dr. Howell?
 13 MS. JONES:
 14 A. Dr. Howell, yes.
 15 CHAYTOR, Q.C.:
 16 Q. And what does it mean though for the director
 17 and clinical chief at this point in time,
 18 November 2006--it's still director and
 19 clinical chief--they're directly accountable
 20 for the laboratory. What does that mean?
 21 MS. JONES:
 22 A. That's overall accountability as a co-
 23 leadership team.
 24 CHAYTOR, Q.C.:
 25 Q. So, what does that mean in terms of what

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1 happened here in the ER/PR issue?
 2 MS. JONES:
 3 A. I can't really speak to the ER/PR, but the
 4 technical side of the laboratory would have
 5 been Terry's responsibility. And the
 6 administrative side and the physician side of
 7 the laboratory would have been in through the
 8 divisional chiefs and ultimately to the
 9 clinical chief.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. So, if there were any issues regarding
 12 the technical side of things or the
 13 administrative side of things within the
 14 laboratory -
 15 MS. JONES:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. - if there were any issues or problems
 19 identified which may have contributed or
 20 caused the problem -
 21 MS. JONES:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. - Mr. Gulliver is accountable.
 25 MS. JONES:

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1 A. Hm.
 2 CHAYTOR, Q.C.:
 3 Q. If there's any issues on the physician side of
 4 things which may have caused or contributed -
 5 MS. JONES:
 6 A. Then it would have been Dr. Denic.
 7 CHAYTOR, Q.C.:
 8 Q. - the clinical chief.
 9 MS. JONES:
 10 A. That's right. Those were the streams.
 11 CHAYTOR, Q.C.:
 12 Q. Dr. Cook, I guess. At different points in
 13 time, it's been different people, but it's the
 14 clinical chief.
 15 MS. JONES:
 16 A. That's right. And that would be no different
 17 that we have in all of the program areas that
 18 would have been the old health care
 19 corporation or into Eastern Health in my old
 20 portfolio. We would have a program director
 21 responsible for the day-to-day operations,
 22 budgets, those kinds of things and then we
 23 would have a physician chief or a clinical
 24 chief responsible for the physician side of
 25 that. But they work together from the

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1 perspective of planning the program and where
 2 the program needs to move, doing the budget,
 3 the strategic planning, those kinds of things.
 4 So, together they do those sorts of things.
 5 But on a day-to-day operational side, it would
 6 be the program director. On the physician
 7 side and the equality side for the physician,
 8 the credentialing on all of those things would
 9 fall on the realm of the clinical chief.
 10 CHAYTOR, Q.C.:
 11 Q. And what does it mean that they are
 12 accountable?
 13 MS. JONES:
 14 A. As a team, they are accountable for the -
 15 CHAYTOR, Q.C.:
 16 Q. How are they held accountable?
 17 MS. JONES:
 18 A. They are held accountable through to, in this
 19 instance, it would have been Oscar Howell or
 20 Dr. Williams for the care and the quality of
 21 the work that was done inside the program.
 22 CHAYTOR, Q.C.:
 23 Q. Okay. And has that happened?
 24 MS. JONES:
 25 A. To my knowledge it has.

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1 CHAYTOR, Q.C.:

2 Q. Okay. And when did that happen?

3 MS. JONES:

4 A. In terms of--what particular specific are you

5 asking?

6 CHAYTOR, Q.C.:

7 Q. Is it Dr. Howell's day or was it Dr. Williams'

8 day, for example?

9 MS. JONES:

10 A. For?

11 CHAYTOR, Q.C.:

12 Q. The accountability.

13 MS. JONES:

14 A. In both of them because Dr. Howell right now

15 is responsible for the laboratory.

16 CHAYTOR, Q.C.:

17 Q. Yes.

18 MS. JONES:

19 A. And in Dr. Williams' day, it would have been

20 Dr. Williams. So, for the period in time in

21 which any issue they would have been

22 accountable for what was going on inside the

23 lab.

24 CHAYTOR, Q.C.:

25 Q. So, there's been accountability.

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1 MS. JONES:

2 A. Um-hm.

3 CHAYTOR, Q.C.:

4 Q. There's been accountability for this issue and

5 Dr. Williams and/or Dr. Howell has seen to

6 that.

7 MS. JONES:

8 A. That's right.

9 THE COMMISSIONER:

10 Q. Do you want to break now or if you're on a -

11 CHAYTOR, Q.C.:

12 Q. I had one other issue on -

13 THE COMMISSIONER:

14 Q. - question regarding this exhibit, carry on

15 and -

16 CHAYTOR, Q.C.:

17 Q. I had one other issue on this exhibit, yes.

18 THE COMMISSIONER:

19 Q. All right.

20 CHAYTOR, Q.C.:

21 Q. This is at page 11 of the exhibit, Ms. Jones,

22 and it's quality framework. And included in--

23 this is the same meeting.

24 MS. JONES:

25 A. Yes.

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1 CHAYTOR, Q.C.:

2 Q. Included in the executive package was

3 memorandum from Pat Pilgrim dated the 10th of

4 November, 2006 outlining decisions related to

5 the quality framework.

6 MS. JONES:

7 A. Right.

8 CHAYTOR, Q.C.:

9 Q. And the following summary of the decisions, 1)

10 proceed with the quality framework focused on

11 quality of clinical services. 2) all other

12 aspects of organizational performance will be

13 part of organizational effectiveness.

14 MS. JONES:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. OE framework led by Wayne Miller. Then 3)

18 structures will proceed and include portfolio

19 based quality committees. Reporting templates

20 for directors annual quality reports has been

21 developed. Indicator section will be further

22 developed to reflect regional and program

23 specific indicators. Quality will propose a

24 list of generic quality indicators and an

25 indicated report format; 5) all portfolio

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1 quality committees will report to the regional

2 quality council, a copy of the terms of

3 reference was circulated, reporting process

4 for the regional quality council will be

5 quarterly, with highlights only, required

6 organizational practices, draft plan is being

7 developed by quality and risk management.

8 MS. JONES:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. And my question on this is this is in November

12 of 2006.

13 MS. JONES:

14 A. Uh-hm.

15 CHAYTOR, Q.C.:

16 Q. This is a new framework?

17 MS. JONES:

18 A. A new framework, a regional framework for

19 Eastern Health.

20 CHAYTOR, Q.C.:

21 Q. Okay, and has it now been put in place?

22 MS. JONES:

23 A. It's been evolving and it still evolves, but

24 yes, we have a quality framework, we have

25 portfolio based committees, if you go down to

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1 three, we have a template for reporting, we
 2 are continuing to develop our quality
 3 indicators and the report format on that. All
 4 portfolio quality committees will report to
 5 the regional quality council, that's done.
 6 And required organizational practices, which
 7 comes out of the Canadian Council of Health
 8 Services Accreditation, a plan was developed
 9 by quality and risk management to move forward
 10 on all of those.

11 CHAYTOR, Q.C.:

12 Q. Okay, so there's a Regional and Quality
 13 Council?

14 MS. JONES:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. So that's for the entire eastern Health
 18 region?

19 MS. JONES:

20 A. Yes, yeah.

21 CHAYTOR, Q.C.:

22 Q. Now is that the board committee?

23 MS. JONES:

24 A. No, since--in November of 2006, there was not
 25 a board safety or quality committee. We had

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1 only two committees of the sub-committees of
 2 the board, they would have been a finance
 3 committee and a planning committee. It wasn't
 4 until later, February maybe or through the
 5 fall of this year there was a discussion about
 6 a safety and improvement committee with terms
 7 of reference, as well as executive limitations
 8 and the development of a reporting structure
 9 through a sub-committee of the board and that
 10 has been in place and continuing to evolve, so
 11 that we still have the structures underneath
 12 it about portfolio quality committees, we
 13 still have a regional quality council. We
 14 then report into a safety and improvement
 15 committee of the board, which reports directly
 16 to the board.

17 CHAYTOR, Q.C.:

18 Q. Okay, I think I'll probably leave it at that
 19 today and start tomorrow and we'll look at the
 20 quality framework piece -

21 MS. JONES:

22 A. Yes.

23 CHAYTOR, Q.C.:

24 Q. And I think if you could think about
 25 articulating to us what all the different--

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1 what are the steps, like who has
 2 responsibility, what does the board committee
 3 do, what does quality, regional and how they
 4 all connect and maybe we could pick it up
 5 there tomorrow then.

6 THE COMMISSIONER:

7 Q. All right then, 9:30 in the morning.

8 CHAYTOR, Q.C.:

9 Q. Thank you.

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1 CERTIFICATE

2 I, Judy Moss, hereby certify that the foregoing is
 3 a true and correct transcript in the matter of the
 4 Commission of Inquiry on Hormone Receptor Testing,
 5 heard on the 28th day of April, A.D., 2008 before
 6 the Honourable Justice Margaret A. Cameron,
 7 Commissioner, at the Commission of Inquiry, St.
 8 John's, Newfoundland and Labrador and was
 9 transcribed by me to the best of my ability by
 10 means of a sound apparatus.

11 Dated at St. John's, Newfoundland and Labrador
 12 this 28th day of April, A.D., 2008

13 Judy Moss

<p align="center">-?-</p> <p>' [1] 167:4 '04 [1] 16:15 '06 [1] 304:23 '07 [1] 205:19 '96 [1] 35:18 '97 [4] 35:18 91:11,16 181:5 '99 [1] 181:5 'Pathology [1] 167:2 'til [1] 194:12</p> <hr/> <p align="center">---</p> <p>-I [1] 242:25 -that [1] 126:24 -what [1] 50:9 -you [1] 223:5</p> <hr/> <p align="center">-0-</p> <p>0031 [3] 4:21 5:18,19 0043 [3] 12:6,12,14 0481 [5] 222:8 258:23,25 259:2 283:21 0486 [3] 68:5 85:16 175:25 0487 [2] 5:20 300:11 0488 [1] 5:20 0729 [2] 104:22 132:21 0774 [1] 369:17 0776 [3] 131:12,14,14 0777 [1] 131:14 0778 [2] 131:11,14 0779 [2] 131:14 292:13 0780 [4] 131:17,19,20 293:1 0781 [2] 131:20 294:18 0782 [1] 131:20 0783 [4] 131:20,20,25 298:12 0784 [2] 325:1,10 080 [1] 131:19 0800 [1] 131:15 0830 [2] 131:12,12</p> <hr/> <p align="center">-1-</p> <p>1 [1] 435:9 1.5 [1] 187:7 1.6 [1] 64:24 10 [1] 180:4 101 [1] 261:10 10th [2] 338:10 435:3 11 [1] 434:21 11:30 [1] 46:9 11th [1] 338:10 132 [1] 3:5 13th [3] 291:2 292:17 330:5 15 [1] 130:22</p>	<p>15th [1] 12:23 16th 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