COMMISSION OF INQUIRY
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER

July 4, 2008

Appearances:

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Peter Browne/Jane Hennebury . . . . . . Doctors Kara Laing et al

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

Ches Crosbie, Q.C. . . . . Members of the Breast Cancer
. . . . Testing Class Action

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

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1 COMMISSIONER:
2 Q. Please be seated. Mr. Coffey.
3 COFFEY, Q.C.:
4 Q. Thank you, Commissioner. A couple of
5 administrative items, Commissioner. Please,
6 one Exhibit P-2135, that's 2135.
7 COMMISSIONER:
8 Q. 2135, yes.
9 COFFEY, Q.C.:
10 Q. That actually, I gather from the Registrar,
11 did not go up on the site, although I referred
12 to it a couple of days ago, it didn't go up on
13 the web site. It was indicated to be under
14 review.
15 COMMISSIONER:
16 Q. Yes.
17 COFFEY, Q.C.:
18 Q. And it's not going to be used, so I'd ask that
19 it be cancelled.
20 COMMISSIONER:
21 Q. So that's 2135?
22 COFFEY, Q.C.:
23 Q. Yes.
24 COMMISSIONER:
25 Q. Cancelled as an exhibit.

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1 COFFEY, Q.C.:
2 Q. And, as well, Commissioner, there is another
3 exhibit I would ask to be entered, it's
4 Exhibit P-2137.
5 COMMISSIONER:
6 Q. And that one you had listed as being--yes, all
7 right, that's entered.
8 EXHIBIT P-2137 ENTERED INTO EVIDENCE.
9 COFFEY, Q.C.:
10 Q. Thank you, Commissioner.
11 DR. DONALD COOK, EXAMINATION BY BERNARD COFFEY, Q.C.
12 (CONTINUED)
13 COFFEY, Q.C.:
14 Q. Good morning, Dr. Cook. Registrar, please,
15 Exhibit P-0935? Doctor, yesterday we referred
16 to a template, as it were, for a survey of
17 various centres across Canada at the end of
18 July, 2005?
19 DR. COOK:
20 A. Correct.
21 COFFEY, Q.C.:
22 Q. Okay. Now, this is an e-mail from Janet
23 Laidley who you indicated worked in QI at the
24 time, Thursday, July 28th, 2005, forwarding to
25 yourself and Dr. Williams and Ms. Predham, an

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1 e-mail and attachment, saying, "Attached are
2 the surveys completed as of today, July 28th,
3 from hospitals, labs from across Canada with
4 our survey questions about PR, ER testing."
5 And she notes that there were three that were
6 not available, would not be available until
7 next week. Doctor, did you at the time you
8 received the e-mail with the attachments
9 review these?
10 DR. COOK:
11 A. You mean the survey results?
12 COFFEY, Q.C.:
13 Q. The survey results.
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Okay. And without going to each individual
18 one, the overall impression you had or
19 conclusions you reached were what?
20 DR. COOK:
21 A. No standardization, you had different centres
22 basically using different types of equipment.
23 There was some variability in positivity
24 rates, but not very much from what I can
25 glean. But basically, you know, variation in

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1 equipment from site to site.
2 COFFEY, Q.C.:
3 Q. I take it that that was, in effect,
4 confirmation of what the impression you had
5 already reached?
6 DR. COOK:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. Exhibit P-0535, please? Now, Doctor, this is
10 a four-page letter, it's dated July 29th, 2005
11 from Dr. Joy McCarthy. It's drafted for both
12 Dr. Carter and your own signature. And this
13 appears to be the third in a series of
14 reporting letters to Dr. McCarthy about repeat
15 estrogen receptor and progesterone receptor
16 results on retesting with the Ventana?
17 DR. COOK:
18 A. Correct.
19 COFFEY, Q.C.:
20 Q. And, Doctor, when we look down through this,
21 the first page seven results are all 2002 and
22 then the next page ten results or ten
23 different, yes, retest results are all 2002.
24 The third page, the first two are 2002 and
25 then after that there's retest results for an

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1 '05 patient, 2000, seven, 2003 patients. And
2 on the fourth page there are four 2003
3 patients at the top of the page and then five
4 2004 patients. See those?
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Doctor, what then had happened in the last two
9 weeks of July in terms of retesting?
10 Obviously some more 2002s were done?
11 DR. COOK:
12 A. Yes, that was the primary year we were centred
13 on.
14 COFFEY, Q.C.:
15 Q. Sure. But I'm sure we would have had a
16 discussion on what was happening over other
17 years and whether we could rule out conversion
18 in other years and come to the conclusion that
19 we couldn't be absolutely certain of ruling
20 out conversions over the years. I guess at
21 some point in time, I don't know exactly when,
22 the oncologist would have brought to us a
23 paper supporting the benefit of Tamoxifen
24 therapy over a ten-year period, so that would
25 have, you know, leaned us to go towards

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1 retesting from the time we started
2 immunoperoxidase stains right up to the
3 present day, around 2005.
4 DR. COOK:
5 A. And here, Doctor, on the third page of the
6 exhibit, when we look at the--well, there's
7 one there for 2005, it's the third--I
8 apologize, that's not right, it's the fourth
9 page--third page. The third entry on that
10 page is for a 2005 patient. Here on retest on
11 the Ventana the results were negative and
12 negative, which is confirming, I take it,
13 probably the original result?
14 DR. COOK:
15 A. Correct.
16 COFFEY, Q.C.:
17 Q. And then there's one from 2000, which if it
18 was originally negative is certainly a
19 conversion, there's a 90 and an 80 in terms of
20 ER and PR results. Then in '03, when one
21 looks down through it, there are some--
22 assuming that the original tests, these were
23 only being retested if they were originally
24 called negative, some of the '03s have here
25 then converted, but a number are confirmations

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1 of original negatives. You see that here?
2 DR. COOK:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Okay, so we go into the next page, as well,
6 the fourth page of the exhibit, one at the top
7 of the page, they're assuming that it wouldn't
8 have been retested unless it was originally a
9 negative for ER, here we have strong nuclear
10 positivity in 100 percent of cells in this '03
11 case, but then the next three are
12 confirmations of negative results?
13 DR. COOK:
14 A. Correct.
15 COFFEY, Q.C.:
16 Q. And I take it the same thing then when you
17 look through 2004 cases, toward the bottom of
18 the fourth page of the exhibit, some of them
19 are confirmed negatives and if the original
20 tests were, the results in '04 were negative,
21 these would be conversions, these two here?
22 DR. COOK:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. So I take it then that for 2003 and 2004, as

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1 of the end of July on the Ventana retest some
2 of the results were confirming the original
3 results and some were--there were, though,
4 some conversions?
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Okay. The Exhibit P-0536, please?
9 COMMISSIONER:
10 Q. Mr. Coffey, before you move on.
11 COFFEY, Q.C.:
12 Q. Yes.
13 COMMISSIONER:
14 Q. There's a point that Dr. Cook mentioned that I
15 wanted to explore. You said something about
16 the oncologist having brought you a paper
17 regarding the benefits of Tamoxifen?
18 DR. COOK:
19 A. That's correct, Commissioner. I think that
20 was sometime earlier in the process when we
21 were making a decision to how far we go back
22 and do the retesting. We would have told the
23 oncologists that we started testing sometime
24 in '97, so the issue is, is there a value
25 going back that far and retesting the

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1 patients. And we got the information from
2 them that they produced a paper, and I can't
3 tell you exactly what that paper was, that
4 there was evidence of benefit of Tamoxifen up
5 to, I believe, ten years.
6 COMMISSIONER:
7 Q. Ten years from the point of the original -
8 DR. COOK:
9 A. Diagnosis.
10 COMMISSIONER:
11 Q. - diagnosis, okay. Thank you.
12 COFFEY, Q.C.:
13 Q. I anticipate in due course, Commissioner, that
14 you'll see that paper and -
15 COMMISSIONER:
16 Q. All right, thank you.
17 COFFEY, Q.C.:
18 Q. - the references to it. Exhibit, yes, P-0536,
19 Doctor. This is a letter from Dr. Williams to
20 yourself, July 29th, 2005. He writes to you,
21 "The following suggestions are made for Dr.
22 Carter's and your best advice on how to
23 proceed from here." And then there's some
24 suggestions from Dr. Williams. New testing
25 results, send out ER/Pr for staining at an

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1 outside lab for the next few months. Process
2 the same slides here, have both slides read by
3 the same pathologist. Check comparability
4 between stains and when we are satisfied,
5 revert to processing here." Paragraph 2,
6 "Retesting of the negative results reviewed by
7 pathology type and in consultation with
8 oncologist to see which cases should be re-
9 stained and reviewed. These cases should
10 follow the same procedures as outlined from
11 number one above." Number three, "Ask Ventana
12 to send out one of their technical experts
13 very soon to look at our staining technique."
14 Doctor, were these actual suggestions from Dr.
15 Williams to yourself and Dr. Carter or was
16 this advice yourself and Dr. Carter had given
17 Dr. Williams and he was just putting it in
18 written format?
19 DR. COOK:
20 A. No, there would have been various discussions
21 between myself and Dr. Williams over, you
22 know, how to proceed in the next few months
23 with the ER and PR issue, so some of the stuff
24 he's got there on paper, myself and Dr.
25 Williams would have discussed a few days

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1 before that. So I think he put some extra
2 items on the paper just for discussion
3 purposes only.
4 COFFEY, Q.C.:
5 Q. Okay. And look, please, at Exhibit P-0937?
6 This is the same letter, although it's got
7 some handwriting on it. Do you recognize the
8 handwriting?
9 DR. COOK:
10 A. That's Dr. Carter's.
11 COFFEY, Q.C.:
12 Q. Carter's, okay. And when you received this
13 letter from Dr. Williams, did you discuss the
14 matter with Dr. Carter?
15 DR. COOK:
16 A. I believe we would have had discussion, yes.
17 COFFEY, Q.C.:
18 Q. And then what resulted from the letter itself?
19 DR. COOK:
20 A. A plan of action, that we would send the cases
21 out for an outside review and -
22 COFFEY, Q.C.:
23 Q. So that would be the retrospective, I take it?
24 DR. COOK:
25 A. That's the retrospective study. And I'm not

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1 sure by that time--the date of that letter
2 again?
3 COFFEY, Q.C.:
4 Q. It's July 29th, I apologize, Doctor, it's
5 right there.
6 DR. COOK:
7 A. We would have been looking around for a
8 hospital to take that. And as you recollect
9 from my testimony yesterday, I was speaking to
10 the Mayo Clinic and Sloan Kettering and would
11 have been considering Mount Sinai, so that's
12 in regard to her reference there regarding
13 Mount Sinai. So items one and two that were
14 ticked, again, that suggested that the course
15 of action we were going down, down the road.
16 COFFEY, Q.C.:
17 Q. So the idea was was that you'd have the '97 to
18 2005 results retested elsewhere?
19 DR. COOK:
20 A. I believe so.
21 COFFEY, Q.C.:
22 Q. Or at least contemplating it at this point in
23 time?
24 DR. COOK:
25 A. Certainly contemplating it.

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1 COFFEY, Q.C.:
2 Q. If you could find someone to do it, as it
3 were?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. If you were comfortable with doing it, you
8 would have that done?
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And on a go-forward basis would have the
13 slides, at least in the immediate future--I'm
14 sorry, the blocks sent out for testing,
15 initial testing elsewhere, but you would also
16 perform the same test in house?
17 DR. COOK:
18 A. Yeah, we were thinking at the same time of
19 performing that in house.
20 COMMISSIONER:
21 Q. Sorry, just doing a double or sending out -
22 DR. COOK:
23 A. Yeah.
24 COMMISSIONER:
25 Q. - or retaining the new cases in house at that

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1 time?
2 DR. COOK:
3 A. Well, what we were thinking of is, say, we
4 would send out a particular block for
5 retesting. Prior to sending out that
6 particular block for retesting, we would re-
7 stain it--stain it with our own ER/PR here,
8 you'd have your original slides. And those
9 original slides would then be forwarded to the
10 original pathologist for interpretation, not
11 for sign out in the system, for
12 interpretation, and the idea being that they
13 would forward the results back to Dr. Carter.
14 Now, this is coming up later on, but this is
15 getting into the idea of this particular item.
16 Then we would take that block and then forward
17 that block to Mount Sinai for retesting and
18 compare the results of Mount Sinai's
19 interpretation with our interpretation. The
20 reason for that being, at that particular time
21 I was thinking that when we were starting up,
22 we would still be going back for a general
23 list sign out, so I wanted to see the
24 correlations between our pathologists'
25 interpretations and the Mount Sinai

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1 interpretations. So that was the thinking at
2 that particular time.
3 COMMISSIONER:
4 Q. Now, this was on the retest or on the go-
5 forward people?
6 DR. COOK:
7 A. This was on mainly the go-forward people.
8 These are the current cases or prospective,
9 the new cases.
10 COMMISSIONER:
11 Q. Okay, so you would do your blocks, you would
12 have them forwarded to Mount Sinai for
13 preparation of slides and reading and at the
14 same time you would be forwarding those slides
15 from the same blocks to people in house?
16 DR. COOK:
17 A. In house. So the same block, you would have
18 our in house staining, the same block then
19 after that was done was then forwarded to
20 Mount Sinai for their staining and
21 interpretation. So the idea is wanted to
22 create a correlation between our original--our
23 own pathologists and the Mount Sinai results
24 with a view to start up with a general list
25 sign out.

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1 COMMISSIONER:
2 Q. Okay.
3 COFFEY, Q.C.:
4 Q. And on that point, I take it, Doctor, that was
5 at least the thought as of the end of--or a
6 thought, particular possibility as of the end
7 of July, 2005?
8 DR. COOK:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. I take it that that subsequently did not
12 happen?
13 DR. COOK:
14 A. Yes, that's right, and -
15 COFFEY, Q.C.:
16 Q. And do you recall why that was, why -
17 DR. COOK:
18 A. Well, there was a time period that went by, I
19 think the only results that Dr. Carter got
20 were from myself. But there was a time period
21 that went by, I think, up to early, mid
22 October. And you got to remember I was doing
23 a lot of other stuff -
24 COFFEY, Q.C.:
25 Q. Yes.

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1 DR. COOK:
2 A. - at the same time, that Dr. Carter came to me
3 and said "where are the slides for the
4 retest?" and to tell you the truth -
5 COFFEY, Q.C.:
6 Q. For the retest in the sense of the current
7 slides?
8 DR. COOK:
9 A. Current slides done in house.
10 COFFEY, Q.C.:
11 Q. Sure.
12 DR. COOK:
13 A. So I said "I really don't know. I can check
14 on it for you," because around August 8th, I
15 had sent out a memo to our technologists and I
16 went over there to speak to them individually
17 on what I wanted done.
18 COFFEY, Q.C.:
19 Q. Yes.
20 DR. COOK:
21 A. So I think it was sometime in October, I went
22 over there to find out what was happening with
23 the slides, and none had been sent out, as far
24 as I know. I remember speaking to--I think it
25 was -

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1 COFFEY, Q.C.:
2 Q. Sent out to individual pathologists?
3 DR. COOK:
4 A. Individual pathologists.
5 COFFEY, Q.C.:
6 Q. Who requisitioned the ER/PR test in the first
7 place?
8 DR. COOK:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Okay.
12 DR. COOK:
13 A. And then they would then forward that to Dr.
14 Bev Carter. I found out at that time that the
15 slides were not being stained.
16 COFFEY, Q.C.:
17 Q. Were not being stained?
18 DR. COOK:
19 A. That's right.
20 COFFEY, Q.C.:
21 Q. Who told you that, do you recall?
22 DR. COOK:
23 A. I think it was either Mr. Les Simms or Mr. Ken
24 Green. That was the response that I got from
25 them, and the -

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1 COFFEY, Q.C.:
2 Q. Were the slides being done, do you know?
3 DR. COOK:
4 A. The slides were being done. There was a set
5 of slides, they told me that were in the
6 fridge and they were not processing those
7 slides, staining those slides.
8 COFFEY, Q.C.:
9 Q. So they had created, from the blocks, before
10 the blocks went off to Mount Sinai for the
11 current cases -
12 DR. COOK:
13 A. That's correct.
14 COFFEY, Q.C.:
15 Q. - your understanding from the technologists in
16 October was they had created slides, cut the
17 tissue?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Created a slide on which staining could be
22 done?
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. And then had stored the slide in the
2 refrigerator?
3 DR. COOK:
4 A. Right, without staining or forwarding to the
5 reporting pathologist or the pathologist on
6 site.
7 COFFEY, Q.C.:
8 Q. Did you ask him why that was?
9 DR. COOK:
10 A. Well, he said they were under a lot of work
11 and that they were given instruction from Mr.
12 Dyer not to proceed.
13 COFFEY, Q.C.:
14 Q. And did--okay, so in October when you had that
15 discussion, what then happened?
16 DR. COOK:
17 A. Well, I was a little bit upset. I wasn't
18 overly upset. I had wished that Mr. Dyer had
19 called me about that, to let me know about
20 that, but the reason--and I didn't really
21 pursue it, and the reason I really didn't
22 pursue it was that at that time, I had in my
23 mind, if we were going back to sign out, we
24 would go back for subspecialty sign out and
25 limit it to a few pathologists. So it was an

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1 issue, but it wasn't a major issue to be
2 concerned about.
3 COFFEY, Q.C.:
4 Q. Doctor, did you make any inquiries afterward
5 about whether or not there was any staining of
6 those slides?
7 DR. COOK:
8 A. No, I did not.
9 COFFEY, Q.C.:
10 Q. So that if there are such slides at a short
11 period of time and they are stained, you
12 weren't aware of that?
13 DR. COOK:
14 A. I wasn't aware of that.
15 COFFEY, Q.C.:
16 Q. If we could, please, Exhibit P-0938? Doctor,
17 this is a letter of July 29th, 2005. It's
18 addressed to Dr. Ejeckam. It's from Dr.
19 Williams, but it's copied to yourself. I take
20 it--oh, I'm sorry. Here it is. And Ms.
21 Predham, and it's Dr. Ejeckam in his capacity
22 as chairperson of the Surgical Pathology
23 Review Committee. In the third paragraph, it
24 refers to--he says, "we had a chance to have a
25 detailed discussion of the issue of having

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1 adequate medical information on surgical
2 tissue specimens sent to pathology for review.
3 This was an issue that was raised by the
4 Surgical Pathology Review Committee in
5 September 2030. As Dr. Cook was not available
6 for the clinical chiefs meeting of October
7 2003, he addressed it as part of his report to
8 the November meeting of clinical chiefs and
9 this was then referred to the Medical Advisory
10 Committee. After discussions in both those
11 forms, it was decided the clinical chiefs
12 would support the thrust of your
13 recommendation and try to impress upon all
14 staff in their programs the need to have
15 adequate medical information transmitted with
16 surgical specimens. I know although there
17 were some improvements in the quality of
18 information received, especially from the area
19 of obstetrics and gynecology, further
20 discussion and follow up took place with the
21 co-clinical chief of the peri-operative
22 program, Dr. Alan Kwan. He subsequently
23 addressed this in a memo to all surgeons
24 within this organization in June 2004."
25 And then, Dr. Williams goes on to talk

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1 about the fact that "after further medical
2 leadership follow up, it was decided to modify
3 the requisition form for surgical pathology
4 specimens and outline in bold, red letters
5 that adequate medical information would need
6 to be provided before the specimens were
7 processed. I understand this new form has
8 been prepared and gone forward to the forms
9 committee for approval," and he then continues
10 and concludes with that topic by saying "it is
11 my understanding that Dr. Cook consulted with
12 all pathologists during the development of
13 this new form and the approach that is
14 proposed to improve clinical information."
15 And I take it that the proposal here was to
16 put in bold letters, bold print, on the form -
17 DR. COOK:
18 A. That's correct.
19 COFFEY, Q.C.:
20 Q. - that if it's not filled out properly, the
21 specimen is going to be sent back to the
22 submitter?
23 DR. COOK:
24 A. Submitter to the point of origin.
25 COFFEY, Q.C.:

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1 Q. Point of origin. Now Doctor, I just--the
2 Commissioner has seen references or heard
3 references to this before, but to put this in
4 context here, if we could bring up Exhibit P-
5 0910, please? This is a report of the
6 Laboratory Medical Program to clinical chiefs
7 and Medical Advisory Committee for November
8 and December 2003, and in paragraph 5.0 under
9 quality initiatives, there's a text reading
10 "the Surgical Pathology Review Committee has
11 recently completed a review of requisition
12 forms submitted to the division of pathology.
13 The Committee has found that approximately 80
14 percent of request forms were deficient,
15 particularly in regards to clinical history,
16 which can be very important in the
17 histological evaluation of tissue. A number
18 of options have been recommended by the
19 Surgical Pathology Review Committee, see
20 attached, for discussion at senior levels."
21 And we've seen other material, Doctor,
22 that suggests that this goes back certainly to
23 the time of the formation of the Surgical
24 Pathology Review Committee in April 2003 and
25 even before that, the issue about the forms.

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. Doctor, can you tell or explain to the
5 Commissioner why, from your perspective, as
6 the clinical chief of the Laboratory Medicine
7 Program, when it had been determined by
8 December of 2003 that up to 80 percent or
9 approximately 80 percent of the forms going to
10 pathology were deficient in one or more ways,
11 according to this, and this was now, when we
12 look back, please, at Exhibit P-0938, which is
13 the end of July 2005, it has only then reached
14 the stage of actually having a form printed to
15 try and have the problem fixed or addressed in
16 the sense of ensuring that the forms are
17 filled out properly.
18 DR. COOK:
19 A. Right.
20 COFFEY, Q.C.:
21 Q. I mean, within the milieu in which you work
22 and worked at the time, why would it take that
23 long, bearing in mind the potential negative
24 consequences of not filling out the forms
25 properly, to get people to fill out a form?

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1 DR. COOK:
2 A. That's the nature of the system. That's the
3 nature of the physicians. In regards to
4 filling out requisitions, it's been a long
5 chronic problem in health care for quite a
6 number of years, not just recently, but even
7 when I started as a resident. Trying to get
8 physicians to fill out forms and provide
9 adequate history for the lab, not only the
10 lab, we had the same problem in diagnostic
11 imaging as well. To get them to do that is a
12 significant challenge. I don't know if they
13 recognize the importance of having good
14 history and good correlation with histology so
15 that we can make a good interpretation. The
16 same goes for a radiologist. But it was an
17 issue that had been long standing for quite
18 some time and it's an issue that I thought,
19 and Dr. Ejeckam thought, needed to be
20 addressed. But it is a chronic issue in our
21 health care system in getting proper
22 information put on requisition forms.
23 COFFEY, Q.C.:
24 Q. And from the perspective of the recipient of
25 such a requisition form, you know, in your

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1 career, how at times problematic can that be?
2 DR. COOK:
3 A. It can be problematic, at times. Most of the
4 times it isn't because you're just dealing say
5 with a simple biopsy that you know it's either
6 benign or malignant, but it could be a case,
7 say, where you may have an undifferentiated
8 tumour of the lung given to you and you go
9 through quite a number of differential
10 diagnosis, quite a bit of work up in terms of
11 special stains, immunostains and histochemical
12 stains, only to find out that five or six
13 years ago, this undifferentiated tumour, the
14 patient had a melanoma that has now
15 metastasized to the lung. If you had that
16 information quickly, you would be able to zero
17 in on that particular diagnosis and save time
18 and utilization of scarce laboratory
19 resources.
20 COFFEY, Q.C.:
21 Q. So Doctor, and if I'm--you know, if I'm
22 mischaracterizing it, please tell me so, this-
23 -the experience you've had with respect to the
24 difficulty in having physicians fill out
25 requisition forms adequately, is that a

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1 cultural thing, in the sense of related to
2 medicine and physicians?
3 DR. COOK:
4 A. Related to physicians only?
5 COFFEY, Q.C.:
6 Q. Well, I'm not saying necessarily physicians
7 only. These requisitions generally are filled
8 out by physicians.
9 DR. COOK:
10 A. They are generally filled out by physicians,
11 interns and residents. So it's--I don't know
12 if I'd say cultural thing, but certainly a
13 long standing problem that we've had over the
14 years.
15 COFFEY, Q.C.:
16 Q. And it has--I take it, it continued despite
17 efforts to remedy it?
18 DR. COOK:
19 A. Yes. There for a while, we were getting good
20 return, particularly in some areas such as
21 dermatology and obstetrics and gynecology, but
22 even today, there still remains some problems
23 with getting physicians to fill out these
24 requisition forms and put in adequate history.
25 THE COMMISSIONER:

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1 Q. Sorry to interrupt again, Mr. Coffey, but I
2 just wanted to raise something with Dr. Cook.
3 Dr. Cook, do you have any reason to believe
4 that this lack of cooperation is a lack of
5 understanding of what it is you do as
6 pathologists or is it just people are busy and
7 they're not taking the time?
8 DR. COOK:
9 A. Commissioner, I think it's a mixture of both.
10 I mean, our physicians are very busy. They're
11 going from one place to another, one operation
12 to another, with rounds and committees and
13 whatnot, and the service work. So I think
14 there's certainly a lack of understanding
15 amongst some of them that we can just look
16 down the scope and give an interpretation
17 without knowing the history. So trying to get
18 that point across, and we try to do so at the
19 various rounds that we have, the importance of
20 providing good history that enables us to make
21 the interpretation, because many times, we not
22 only just look at the slide, we also go into
23 the computer system, look at the blood work
24 for various things, correlate our diagnoses
25 with radiology findings and whatnot. So there

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1 is a lot of correlation that goes on between
2 the different disciplines. So you just cannot
3 look many times at a biopsy in isolation. You
4 have to compare it to the clinical picture,
5 the age of the patient, or distribution of
6 various lesions that the patient may have and
7 radiology. Those are your big areas, and
8 communication with your physicians.
9 THE COMMISSIONER:
10 Q. Thank you.
11 COFFEY, Q.C.:
12 Q. Exhibit P-0538, please? Doctor, is this your-
13 -are these your notes?
14 DR. COOK:
15 A. They look like mine, yeah.
16 COFFEY, Q.C.:
17 Q. Okay, yes. Yesterday, you did refer, Doctor,
18 to having short notes on a meeting of August
19 1st with pathologists.
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. And I take it these would be them here,
24 meeting with pathologists, August 1, 2005, and
25 there are five of them.

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Including yourself. I take it these notes
5 here are kind of reminders to yourself, "send
6 out memo regarding point person and site chief
7 for immunoperoxidase."
8 DR. COOK:
9 A. That's correct.
10 COFFEY, Q.C.:
11 Q. And memo for holding of ER/PR?
12 DR. COOK:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And then the reference to the meeting with the
16 pathologists. Dr. Ken Pritzker's name and
17 phone number are here.
18 DR. COOK:
19 A. Right.
20 COFFEY, Q.C.:
21 Q. I take it this is around the time that you
22 would have been contacting Mount Sinai to see
23 if they could take on at least some work?
24 DR. COOK:
25 A. Correct.

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1 COFFEY, Q.C.:
2 Q. That would be correct, okay, and you got here
3 a list of things to do, "test and reconfirm
4 ten cases already ID'ed"?
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. "Retest negative patient, ID to lab program
9 urgent cases. Compare test result with Mount
10 Sinai, get chief for Mount Sinai," chief tech
11 that's probably, is it, "from Mount Sinai to
12 look at techs. Get Allan Gown. Get our
13 system validated very, very"--I'm sorry,
14 "validated very quickly."
15 DR. COOK:
16 A. Right.
17 COFFEY, Q.C.:
18 Q. Doctor, this to-do list at the bottom of the
19 page here, you created that at that point as a
20 result of what? Is this after this larger
21 August 1st meeting?
22 DR. COOK:
23 A. Oh, no, I don't think so. The August 1st
24 meeting would be designed to give those
25 pathologists an update of what was going on.

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1 COFFEY, Q.C.:
2 Q. Not the pathologists meeting. I'm talking
3 about the large meeting with Mr. Tilley and
4 all that.
5 DR. COOK:
6 A. Oh, I get you now, yes. It's possible, Mr.
7 Coffey.
8 COFFEY, Q.C.:
9 Q. And the "ID to lab program urgent cases," I
10 take it this would be to have the oncologists
11 indicate if there were urgent cases, from
12 their perspective, to bring it to your
13 attention?
14 DR. COOK:
15 A. Yes, and I think that refers to the current or
16 the prospective cases where we had newly
17 diagnosed breast cancer and putting in a
18 mechanism whereby we can get a result very
19 quickly.
20 COFFEY, Q.C.:
21 Q. The reference to "get the chief tech from
22 Mount Sinai to look at techs," I take it that
23 ends up being Trish Wegrynowski?
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. Allan Gown, what's that about?
3 DR. COOK:
4 A. I was asked by HIROC if I could identify a
5 physician with a specialty in immunoperoxidase
6 training and evaluation so that they would
7 look at retaining such an individual for their
8 own purposes.
9 COFFEY, Q.C.:
10 Q. And you came up with Mr. Gown's--or Dr. Gown's
11 name?
12 DR. COOK:
13 A. That's correct.
14 COFFEY, Q.C.:
15 Q. Okay, and you say "get our system validated
16 very quickly", what was that about?
17 DR. COOK:
18 A. Oh that was talking about restarting the
19 Ventana system as quickly as possible.
20 COFFEY, Q.C.:
21 Q. Now, if we could, Exhibit P-0079 please?
22 Doctor, this is a letter of August 2, 2005.
23 It's to yourself, it's from Dr. Carter, he's
24 copied it to Dr. Williams and this is the
25 letter where she begins, "Regretfully I inform

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1 you that I wish to withdraw from my
2 organizational role in the investigation of
3 the problems with ER/PR testing at the Health
4 Care Corporation of St. John's from '97 to
5 2004 and the planning of solutions to the
6 current issues discovered with the Ventana
7 Automated System." And then she goes on to
8 speak of the meeting with George Tilley on
9 August 1st. And she, in the third paragraph,
10 says, "It also became clear to me during that
11 meeting that the current administrative
12 structure within Eastern Health and within the
13 laboratory allows decisions regarding the
14 development of a reliable and reproducible
15 system for assessing hormone receptor status
16 to remain in the hands of para-professional
17 staff within the laboratory." And she
18 concludes by saying, "I regret not being able
19 to participate fully in this process, but I am
20 very uncomfortable placing my professional
21 licensure in the forefront of this operation,
22 risking my reputation, locally, nationally and
23 internationally, as an expert in breast
24 pathology." And she has, and I did--at the
25 bottom of the first page she did say, "I am

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1 happy to provide my professional opinion, as a
2 fellowship trained breast pathologist and
3 Chair of the Quality Control Committee for
4 Surgical Pathology at Eastern Health, whenever
5 it is sought." And she emphasizes "it will be
6 an advisory role only". And she's not going
7 to accept or she doesn't want it "misconstrued
8 as accepting any responsibility for
9 procedures, protocols or ER/PR results
10 generated in our laboratory." Now, Doctor,
11 did you know this letter was coming?
12 DR. COOK:
13 A. No, I didn't.
14 COFFEY, Q.C.:
15 Q. And did you receive it on August 2nd or 3rd,
16 around that time?
17 DR. COOK:
18 A. Around that time in my office.
19 COFFEY, Q.C.:
20 Q. And you got it and read it, did you speak to
21 Dr. Carter about it?
22 DR. COOK:
23 A. I read it, I may have spoken to her probably a
24 day after, a day or two after I got the
25 letter.

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1 COFFEY, Q.C.:
2 Q. And coming out of the meeting of August 1st,
3 2005, before--between the time you left the
4 meeting and the time you got this letter, did
5 you speak to Dr. Carter about what had
6 happened at the meeting?
7 DR. COOK:
8 A. Not until a day or so later.
9 COFFEY, Q.C.:
10 Q. Okay, after you got the letter.
11 DR. COOK:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. Okay, and what do you recall about your
15 discussion with her?
16 DR. COOK:
17 A. Well she was very upset, as she stated there,
18 over the management structure, the fact that
19 we have two arms within the Laboratory
20 Medicine Program, the technical arm and the
21 medical arm. The medical arm reporting to me
22 and the technical arm reporting to Mr. Terry
23 Gulliver, Program Director. And she was
24 concerned over the fact that the medical
25 physicians didn't have that degree of control

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1 and authority over the technical arm as what
2 she had seen in other hospitals and she was
3 also worried about the, I suppose, the degree
4 of co-operation taking place between the
5 medical and technical aspects of the
6 Laboratory Medicine Program. So she was quite
7 concerned about the fact that the technical
8 aspect was fully under control of the Program
9 Director and Divisional Manager with, what she
10 thought, without significant advice and
11 guidance from the medical authority.
12 COFFEY, Q.C.:
13 Q. Okay, so yourself and her discussed the
14 matter. What, if anything, did you say to
15 her?
16 DR. COOK:
17 A. Well, I was distressed that she had removed
18 herself from the review process. I was
19 relying on her to conduct the review and
20 provide me with updates on what she found with
21 the review, but more so than that, I was
22 looking for an individual to see this whole
23 review process through. So, I didn't want to
24 pressure her, I mean, she was very upset at
25 that particular period of time and I felt that

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1 if she stayed on within Eastern Health that
2 she would help us with the, as a resource
3 person for breast pathology, continue on as a
4 role as a contributor to breast pathology, as
5 opposed to being involved in this process.
6 COFFEY, Q.C.:
7 Q. Now did you try to change her mind?
8 DR. COOK:
9 A. I tried to, but Dr. Carter has a--once she has
10 a very strong opinion about something, it's
11 quite difficult to change that opinion.
12 COFFEY, Q.C.:
13 Q. From your own perspective as the clinical
14 chief and by that point, you mean clinical
15 chief since 2002 and a year before that even,
16 '99 to 2000.
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. What were your own views at that time as to
21 the structure of the Laboratory Medicine
22 Program?
23 DR. COOK:
24 A. It was a different -
25 COFFEY, Q.C.:

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1 Q. Bearing in mind her complaints about the
2 structure.
3 DR. COOK:
4 A. Yeah, it was a structure that was, at times,
5 difficult to work with. If I can, if I go
6 back prior to '95, '96, when you had hospitals
7 as being their own separate institutions, you
8 look at the lab at that particular time in
9 which we had one director of Laboratory
10 Medicine, in which we had both the laboratory,
11 the technical aspect and medical aspect
12 reporting to the Director of Labs, who was a
13 laboratory physician. That process seemed to
14 be much more streamlined, it was well
15 developed. Everybody within the organization
16 and in particular, the lab, knew exactly who
17 to report to and who the final authority
18 stopped with. So it seemed to be a much more
19 effective structure than what we were dealing
20 with in program base management with basically
21 two streams of thought in the Laboratory
22 Medicine Program. I would say that eventually
23 over a period of time the two arms became more
24 widely separated, in terms of where the
25 program was to go. There was more segregation

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1 of the two arms, I would say.
2 COFFEY, Q.C.:
3 Q. And as that segregation grew, developed and
4 grew, did you ever complain to anybody about
5 it?
6 DR. COOK:
7 A. Yes, I spoke to Dr. Williams on a number of
8 occasions. In 2003 when we had issues
9 concerning the centralization of laboratory
10 services and following this meeting that we
11 had on August 1st and the issues surrounding
12 the segregation of both the medical and
13 technical arms. My suggestion to him was that
14 I think we need to re-evaluate this type of
15 management structure and revert to a system
16 where we have both the medical and the
17 technical reporting under the laboratory
18 director, who is a laboratory physician.
19 COFFEY, Q.C.:
20 Q. And his response?
21 DR. COOK:
22 A. His response was at that particular time, I
23 think he was seeing what was happening, the
24 amount of activity that was going on in the
25 Laboratory Medicine Program, the issues of the

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1 two arms being segregated. I think he was
2 beginning to realize the need to have the
3 program under a single physician.
4 COFFEY, Q.C.:
5 Q. So when you raised it in 2003 with him, I take
6 it nothing had become of that?
7 DR. COOK:
8 A. No, my understanding was that he would be
9 meeting with the executive committee on that
10 and he may have met with them, but I don't
11 know what came out of that.
12 COFFEY, Q.C.:
13 Q. And when I say "nothing became of it", from
14 your perspective, nothing changed?
15 DR. COOK:
16 A. That's correct.
17 COFFEY, Q.C.:
18 Q. Exhibit P-0542 please? Doctor, this is a memo
19 from yourself to all pathologists and to Mr.
20 Gulliver and Mr. Dyer, August 2, 2005. It's
21 "Re: Resource Individual for
22 Immunohistochemistry." And you said, "Doctor
23 Gershon Ejeckam is currently our resource
24 person for immunohistochemistry, all inquiries
25 regarding immunohistochemistry should be

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1 referred to Dr. Ejeckam. In the event that
2 Dr. Ejeckam is not available, all inquiries
3 will be referred to the site chief, General
4 Hospital site, who is currently Dr. Dan
5 Fontaine." So in relation to Dr. Fontaine, I
6 take it that he was appointed site chief
7 effective August 1, does that sound about
8 right?
9 DR. COOK:
10 A. Dr. Dan Fontaine? No, he was site chief March
11 of '05, I believe.
12 COFFEY, Q.C.:
13 Q. Okay, but certainly by August 2nd, he was
14 certainly site chief.
15 DR. COOK:
16 A. Oh, he was site chief by August 2nd, yes.
17 COFFEY, Q.C.:
18 Q. And have there ever been written advisory, do
19 you recall, advising like the pathologists and
20 Mr. Gulliver, Mr. Dyer that Dr. Ejeckam was
21 the resource person for immunohistochemistry
22 before this?
23 DR. COOK:
24 A. No, there was never a written advisory, that
25 again, gets back to our ways, traditionally of

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1 historically doing things, that individuals
2 were taking over positions in the past without
3 the documentation and job descriptions and
4 whatnot, so this was trying to change the ways
5 we were doing things and get into a much more
6 of a documentation process.
7 COFFEY, Q.C.:
8 Q. And what sort of inquiries were you referring
9 to here? "All inquiries regarding
10 immunohistochemistry."
11 DR. COOK:
12 A. Well these, more likely would be referring to
13 the quality of the stains or having a resource
14 person available there to help in
15 interpretation of stains, but in that
16 particular regard, Dr. Dan Fontaine, it would
17 be more a request, if there was a problem with
18 turn-around times of slides, to investigate
19 into that and have Dr. Fontaine report back to
20 the original pathologist.
21 COFFEY, Q.C.:
22 Q. In terms of the quality of stains issue, I
23 take it that would be Dr. Ejeckam?
24 DR. COOK:
25 A. That would be, yes, in regards to the quality

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1 of the stain itself.
2 COFFEY, Q.C.:
3 Q. At the time you sent this out, had you told
4 Dr. Ejeckam you were doing this?
5 DR. COOK:
6 A. No, this was at a time that he was on vacation
7 and I may have sought him down to advise him
8 on the ER and PR issue, so I was aware that he
9 was out of town at that particular time and I
10 also wanted to shore up that in the event that
11 Dr. Ejeckam who was overseeing
12 immunohistochemistry was out of town, that we
13 would have someone cover his duty.
14 COFFEY, Q.C.:
15 Q. Now when Dr. Ejeckam returned from vacation,
16 did you speak to him about it?
17 DR. COOK:
18 A. In regards to this?
19 COFFEY, Q.C.:
20 Q. Yes.
21 DR. COOK:
22 A. I can't remember. I remember speaking to him
23 about the issue at hand with ER and PR. We
24 may have had discussion regarding this.
25 COFFEY, Q.C.:

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1 Q. And if you did, you can't recall?
2 DR. COOK:
3 A. Well I can recall a discussion, but not
4 particularly what was in the discussion.
5 COFFEY, Q.C.:
6 Q. And the idea that he would be the resource
7 person and what types of inquiries he should
8 respond to or what his role in this was, I
9 take it that was not detailed with him and if
10 it was, you can't recall it?
11 DR. COOK:
12 A. I can't recall, but it may have been, Mr.
13 Coffey, but I mean, I can't recall.
14 COFFEY, Q.C.:
15 Q. If I could, please, Exhibit P-0543? Now this
16 is a letter of August 2nd, 2005, it's
17 indicated to be faxed, this is your
18 handwriting on that day, to Dr. Pritzker at
19 Mount Sinai from yourself, and you indicate
20 "As discussed in our telephone conversation,
21 I'm currently putting a hold on the reporting
22 of all estrogen and progesterone receptors
23 from our Laboratory Medicine Program at
24 Eastern Health. For all urgent and newly
25 diagnosed patients with breast cancer, I

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1 certainly appreciate your laboratory's
2 assistance in performing immunohistochemical
3 staining, with interpretative results on these
4 cases. I anticipate that we may be dealing
5 with anywhere from 30 to 40 cases per month,
6 possibly over a three month period. We will
7 correlate Mount Sinai's results with our own
8 to further help us validate our Ventana
9 automated system. I will be in contact with
10 Maria Mendes at your laboratory regarding
11 this. We will, of course, reimburse Mount
12 sinai for all costs incurred. Thank you for
13 your help at this difficult time." Doctor,
14 this discussion you had had with Dr. Pritzker,
15 do you recall that?
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. And what do you recall about it?
20 DR. COOK:
21 A. Well there were some initial discussions, I
22 believe, I would have talked to Ken about the
23 fact that we've had our ERs and PRs on hold,
24 that we were looking for a laboratory to help
25 us with the review, but also we needed a

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1 mechanism in place to handle the newly
2 diagnosed current cases. So this would have
3 been a process that we would have set up to
4 ensure that this was carried out.
5 COFFEY, Q.C.:
6 Q. So he was agreeable for Mount Sinai doing the
7 current cases?
8 DR. COOK:
9 A. That's correct.
10 COFFEY, Q.C.:
11 Q. And the retrospective review?
12 DR. COOK:
13 A. As well, I don't know if we talked about the
14 retrospective in that particular discussion or
15 whether we had different discussions regarding
16 the currents or the retrospectives.
17 COFFEY, Q.C.:
18 Q. In terms of--by this point anyway, by August
19 2nd, in terms of the current cases, 30 to 40 a
20 month for the prospective or current cases,
21 possibly over a three month period, I take it
22 at that point you were envisaging that you
23 might start retesting in St. John's within
24 three to four months?
25 DR. COOK:

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1 A. That's correct.
2 COFFEY, Q.C.:
3 Q. And there's a reference to the correlation
4 with Mount Sinai's results. Was it he who
5 gave you Maria Mendes' name?
6 DR. COOK:
7 A. That's correct.
8 COFFEY, Q.C.:
9 Q. Exhibit P-0939 please? Doctor, this is an e-
10 mail of August 3rd, 2005 from yourself to Dr.
11 Banerjee, subject is "The St. John's Trip".
12 You write, "As discussed, I certainly
13 appreciate your coming to St. John's to review
14 our immunohistochemistry lab during the dates
15 of September 15th, 16th, 2005. We will, of
16 course, reimburse you for all costs incurred
17 your consult, including your consultation fee,
18 we'll keep in contact regarding information
19 that you will need. Regards, Don Cook." So
20 had you known Dr.--first of all I'll ask you,
21 had you known Dr. Pritzker before?
22 DR. COOK:
23 A. Dr. Pritzker, yes, I've known him a number of
24 years.
25 COFFEY, Q.C.:

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1 Q. Okay. And that would be in the context of the
2 CAP, I take it, and professionally otherwise.
3 DR. COOK:
4 A. Well, we meet at the annual meetings of the
5 Canadian Association of Pathologists.
6 COFFEY, Q.C.:
7 Q. How about Dr. Banerjee?
8 DR. COOK:
9 A. Dr. Banerjee I met through the CAP. He was on
10 the executive of the CAP the same time I was.
11 COFFEY, Q.C.:
12 Q. And you've indicated in this e-mail to Dr.
13 Banerjee, "as discussed", what do you recall
14 about your initial discussion with Dr.
15 Banerjee?
16 DR. COOK:
17 A. Well, very much as I said to other
18 individuals. I discussed with--you know, my
19 conversation within other individuals of the
20 Mayo Clinic and whatnot, I would have given
21 him a background, and I believe I had a
22 discussion with him back on August 2, the day
23 before of the index case, the number of
24 samples we retested, the conversion rates that
25 we have identified and information about us

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1 shutting down the ER and PR service and the
2 need for an individual to come in and do an
3 external review.
4 COFFEY, Q.C.:
5 Q. And Doctor, did you pass on to Dr. Banerjee at
6 the time, the observations you had made
7 yourself concerning the original ER and PR
8 slides you'd reviewed up to then?
9 DR. COOK:
10 A. In this conversation?
11 COFFEY, Q.C.:
12 Q. Yes.
13 DR. COOK:
14 A. I don't believe so.
15 COFFEY, Q.C.:
16 Q. Okay. And so what was his reaction? Was he
17 prepared to -
18 DR. COOK:
19 A. He was prepared to come down and do the
20 review.
21 COFFEY, Q.C.:
22 Q. And so from your perspective at the time, he
23 understood he was coming here to do what?
24 DR. COOK:
25 A. A review of the laboratory medicine program at

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1 the time.
2 COFFEY, Q.C.:
3 Q. So, that was the current situation.
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And how about the past results?
8 DR. COOK:
9 A. I don't know about--the current situation in
10 regards to the structure of the lab, what was
11 going on within the lab and a view to try to
12 identify what had happened with or what had
13 caused the conversions.
14 COFFEY, Q.C.:
15 Q. Okay. Which would require some little--
16 something that had gone on before.
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Exhibit P-0545, please. Doctor, these are
21 some notes of Dr. Williams, page two we have
22 the typed version and notes here, "met with
23 Dr. Don Cook and Ms. Heather Predham, times
24 two". And these are notes on PR, ER issues.
25 "QI follow-up and interviews were held with

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1 techs involved in the immunohistochemistry in
2 the a.m. Heather Predham gave me a debriefing
3 on the issue and the lack of communication
4 between techs and pathologists. Heather
5 Predham gave Dr. Cook and general site chief,
6 Dr. Dan Fontaine, a briefing on her interview
7 in the p.m. Met with Dr. Cook afterwards and
8 discussed the issue and the need for techs to
9 have a pathologist who they can go to for
10 advice and communication. Dr. Cook and I will
11 follow-up with Mr. Gulliver on broad and
12 specific communications issues identified.
13 Dr. Cook waiting to hear from Mount Sinai re:
14 completing all negative ER and PR testing on a
15 very expeditious basis".
16 So, Doctor, this meeting of August 3, the
17 issue related to communications between the
18 technologists and the pathologists that's
19 referred to that Heather Predham had, I won't
20 say uncovered so much as reported on.
21 DR. COOK:
22 A. Um-hm.
23 COFFEY, Q.C.:
24 Q. Was that new to you?
25 DR. COOK:

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1 A. Yeah, I was surprised by that briefing that
2 Heather had given us.
3 COFFEY, Q.C.:
4 Q. What do you recall she said to you?
5 DR. COOK:
6 A. Basically the lack of guidance, the lack of
7 coordination that was taking place between the
8 medical and--between our technologists and
9 pathologists. There wasn't a good flow of
10 information between the two groups and issue
11 of who basically was reporting to whom. The
12 fact that she outlined the problem of the two
13 arms being segregated, she believed, was
14 contributing to the issue at hand.
15 COFFEY, Q.C.:
16 Q. That's the ER/PR issue, I take it, and
17 immunohistochemistry?
18 DR. COOK:
19 A. No, into the issue of overall communications.
20 COFFEY, Q.C.:
21 Q. Communications, okay.
22 DR. COOK:
23 A. And dialogue within the program.
24 COFFEY, Q.C.:
25 Q. And you were asked to follow up with Mr.

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1 Gulliver. Did you do that?
2 DR. COOK:
3 A. That would have been between myself and Dr.
4 Williams.
5 COFFEY, Q.C.:
6 Q. Yes.
7 DR. COOK:
8 A. And I believe we did talk about the need or
9 what was happening within the program and I
10 think--and if I remember the conversation with
11 Dr. Gulliver--Mr. Gulliver, he also recognized
12 the issues, the problems of the segregation of
13 the two arms.
14 COFFEY, Q.C.:
15 Q. And were there any plans arrived at as to how
16 it might be addressed?
17 DR. COOK:
18 A. Well, again, closer cooperation with the site
19 chiefs. I mean, there had been--there is a
20 structure in place in there where we had a
21 site chief who was supposedly there to act as
22 liaison between the medical and technical
23 arms. Dr. Fontaine, being at that meeting,
24 was certainly aware of the need for smooth
25 communication and liaison with that. And

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1 what--this is probably around the time that I
2 would have been recommending or starting to
3 push for the medical and technical arms
4 reporting to the clinical chief and to try to
5 streamline this process. Now, Mr. Gulliver,
6 at that time, wasn't too receptive to that,
7 but this was something that I was beginning to
8 push harder and harder.
9 COFFEY, Q.C.:
10 Q. You were pushing with whom?
11 DR. COOK:
12 A. Dr. Williams.
13 COFFEY, Q.C.:
14 Q. Okay. The third last bullet here on this page
15 refers to the need for techs to have a
16 pathologist who they can go to for advice and
17 communication.
18 DR. COOK:
19 A. Um-hm.
20 COFFEY, Q.C.:
21 Q. In this context who was that?
22 DR. COOK:
23 A. I can't remember if we were actually talking
24 about Dr. Fontaine or Dr. Ejeckam, so I can't
25 recollect specifically who were talking to.

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1 If we were talking regarding to
2 immunohistochemical techs, it would have been
3 Dr. Ejeckam.
4 COFFEY, Q.C.:
5 Q. This, because the first--the second bullet
6 says, "Techs involved in the
7 immunohistochemistry" are the people who
8 apparently Ms. Predham had--techs involved in
9 the immunohistochemistry in the a.m. So in
10 that context, I take it, that would be Dr.
11 Ejeckam?
12 DR. COOK:
13 A. On the second bullet?
14 COFFEY, Q.C.:
15 Q. Second bullet.
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. So the communications issues that you were
20 alerted to on August 3rd, were they limited to
21 the IHC techs or were they wider? Was the
22 communication in a wider sense involving
23 histology and other matters, as well, or was
24 it just the IHC?
25 DR. COOK:

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1 A. No, I think they were in a wider, wider sense
2 with the histology techs and our pathologists.
3 COFFEY, Q.C.:
4 Q. Exhibit P-0940, please? This is an e-mail
5 from Heather Predham August 4, 2005, to
6 yourself and Dr. Williams. This conversion or
7 66 percent conversion rate, is that your
8 handwriting?
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Do you recall what that was in relation to at
13 that time?
14 DR. COOK:
15 A. Oh, that's probably in relation to the first
16 two batches, the batch of 25 and the batch of
17 33.
18 COFFEY, Q.C.:
19 Q. An overall conversion rate of 66 -
20 DR. COOK:
21 A. Well, approximately. I mean, I was using
22 ranges for most of that period of anywhere
23 from 60 to 65 to 66 percent, so I was using
24 rough figures. So, you know, I don't know if
25 that's totally accurate, but, I mean, this was

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1 sort of a conversion rate that I was quoting,
2 giving a range.
3 COFFEY, Q.C.:
4 Q. Doctor, here by conversion you meant what?
5 DR. COOK:
6 A. From a negative result to a positive.
7 COFFEY, Q.C.:
8 Q. And would that be a negative result in ER or a
9 negative result in PR?
10 DR. COOK:
11 A. At that time, ER.
12 COFFEY, Q.C.:
13 Q. Now, the e-mail itself says, "I just want to
14 let you know that I met the technical expert
15 from Ventana this a.m. with Terry and Barry.
16 We went over the issues and what we needed
17 from her. Terry told her that we would be
18 meeting with her tomorrow to hear her
19 assessment of our system." And then there's a
20 discussion about a reference to Terry having
21 raised the issue whether the 58 cases that we
22 retested were all negatives or did they
23 include weak positives, as well. And toward
24 the end of the e-mail there's a reference to,
25 "As well, Barry will pull the cases tested

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1 between June 29 and November 1st to confirm
2 that all results in that period of time were
3 negative." What was that about?
4 DR. COOK:
5 A. This was an issue here, again, we're getting
6 into the issue of what you regard as cutoff,
7 clinical cutoff or technical cutoff. So Dr.
8 Carter would have pulled cases that were
9 regarded clinically as negative, that is,
10 cases less than ten percent, while our
11 technical staff were regarding anything as
12 less than or equal to one percent as being
13 negative. So this was an issue of what was
14 being defined as negative.
15 COFFEY, Q.C.:
16 Q. So, had there been some suggestion that there
17 were no positive cases during that timeframe?
18 DR. COOK:
19 A. After June?
20 COFFEY, Q.C.:
21 Q. Yes, between June 29 and November 1, 2002
22 because we've seen other references to that.
23 DR. COOK:
24 A. I believe somebody made a suggestion regarding
25 that.

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1 COFFEY, Q.C.:
2 Q. Do you recall who that was?
3 DR. COOK:
4 A. I think that was Dr. Carter. I can't be
5 absolutely sure on that.
6 COFFEY, Q.C.:
7 Q. So, Mr. Dyer, at this point, I take it, was
8 going to see, to check -
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. - the actual pathology reports.
13 DR. COOK:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. What then happened with respect to that?
17 DR. COOK:
18 A. I think he checked and found that we did have
19 positive cases after that time period.
20 COFFEY, Q.C.:
21 Q. Or during that time period?
22 DR. COOK:
23 A. Or during.
24 COMMISSIONER:
25 Q. Positive cases in whose definition?

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1 COFFEY, Q.C.:
2 Q. Or either definition.
3 DR. COOK:
4 A. It could be either technical or clinical, but
5 I think more so in technical and that is
6 greater than one percent.
7 COFFEY, Q.C.:
8 Q. If we could, please, Exhibit P-0552. Now
9 Doctor, this is a report August 5, 2005, it's
10 addressed to Terry Gulliver, it's from Carole
11 Quevillon of Ventana and she advises Mr.
12 Gulliver here that I've checked the Ventana
13 benchmark instruments, the procedure and
14 protocols used for the ER and PGR stains, the
15 knowledge and capacity of the technicians to
16 troubleshoot and run the instruments". And I
17 take it that overall here, because the
18 Commissioner has seen this before, overall
19 here, her report was that the technicians, as
20 she describes them, know what they are doing;
21 they know how to use the instruments and she
22 says she feels confident that the benchmark
23 instruments are staining as they should be.
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. And her one recommendation was that
3 maintenance procedures, monthly and quarterly
4 had not been done and they should be done.
5 DR. COOK:
6 A. That's correct.
7 COFFEY, Q.C.:
8 Q. So, Doctor, you would have become aware of
9 this around that time.
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. What, if any, significance did that have for
14 you?
15 DR. COOK:
16 A. Well, that had great significance. It gave me
17 a further comfort in that the Ventana system
18 was generally operating as it should. The
19 only issues regarding the maintenance
20 procedures which is something that our techs
21 needed to bone up on, but overall I felt a
22 good degree of comfort, particularly in
23 regards to the fact that we had not shut down
24 the entire immunohistochemical service. So,
25 there was a strong degree of comfort there.

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1 COFFEY, Q.C.:
2 Q. I take it, Doctor, that in fact the only two
3 tests that had been shut down were the ER and
4 the PR?
5 DR. COOK:
6 A. That's correct.
7 COFFEY, Q.C.:
8 Q. The IHC service at that time probably had more
9 than a hundred other stains being run.
10 DR. COOK:
11 A. That's right.
12 COFFEY, Q.C.:
13 Q. More depending upon how routinely each
14 particular one is run, but the machine was
15 going full bore anyway, wasn't it? I mean, it
16 was being used continuously.
17 DR. COOK:
18 A. That's correct.
19 COFFEY, Q.C.:
20 Q. And this gave you some comfort that the
21 machine is working properly, we can continue
22 to use it for all these other stains.
23 DR. COOK:
24 A. That's right.
25 COFFEY, Q.C.:

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1 Q. Exhibit P-0551, please, page two. Again,
2 these are Dr. Williams' notes of a meeting,
3 they list Dr. Laing, Pat Pilgrim, Heather
4 Predham, Dr. Gardiner, yourself and himself as
5 present, August 5, 2005. There's a note here,
6 says, "all patients seen in the clinic since
7 April 2003 that are negative are being
8 retested, patients with metastatic disease and
9 with lobular cancer".
10 DR. COOK:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. What was that about?
14 DR. COOK:
15 A. I can't remember, Mr. Coffey. I don't know
16 where that came from, that statement. I just
17 can't recollect that one.
18 COFFEY, Q.C.:
19 Q. Yes. And I'm not suggesting, in fact, you
20 should. That's his notes at the time he would
21 have made. The second bullet says, "all
22 negatives at ten or less since March 31, 2003
23 to be retested, plus infiltrating lobular and
24 tubular breast cancers". And it goes on,
25 "Heather Predham will identify all patients

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1 and blocks will be pulled to send out". At
2 that point in time, was there--had a firm
3 decision been made to retest all the Ventana
4 cases?
5 DR. COOK:
6 A. Yes, I think, Ventana ER and PR you mean?
7 COFFEY, Q.C.:
8 Q. Yes.
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. There's a reference here to "10 to 11 patients
13 who have converted have been told", you see
14 that there?
15 DR. COOK:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And you would have understood that by then, it
19 would to be 10 or 11 of the first 25?
20 DR. COOK:
21 A. That was the first 25.
22 COFFEY, Q.C.:
23 Q. Yes. Note here, "people's reaction has been
24 good to date. They have been told there was a
25 problem with the testing and we don't know why

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1 yet", do you see that?
2 DR. COOK:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. So, Doctor, was there discussion in these
6 group sessions up to and including this time
7 about what patients should be told?
8 DR. COOK:
9 A. Only those that had converted.
10 COFFEY, Q.C.:
11 Q. Yes, only those who had converted were being
12 told at that point, but what they were to be
13 told.
14 DR. COOK:
15 A. At that time, I'm not sure what was being told
16 to them.
17 COFFEY, Q.C.:
18 Q. And I understand because you wouldn't attend
19 those meetings.
20 DR. COOK:
21 A. No, and I didn't have a good idea myself what
22 was going on; whether this could be as a
23 result of new technology; whether there's a
24 problem with the technical aspect. I mean, I
25 know I was coming into issues regarding

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1 interpretations, but there didn't seem to be
2 one particular area that we could zero in on
3 as to where the problem lagged.
4 COFFEY, Q.C.:
5 Q. Wouldn't it, at the time, Doctor, though had
6 been fair to have characterized the then state
7 of knowledge that it involves technological
8 issues and interpretive issues?
9 DR. COOK:
10 A. Yes, I was looking towards those issues.
11 COFFEY, Q.C.:
12 Q. It was the only two possibilities, but it
13 wasn't limited to the technology, to your
14 knowledge, nor was it limited to
15 interpretation, to your knowledge?
16 DR. COOK:
17 A. No, it was involving both.
18 COFFEY, Q.C.:
19 Q. So, from a literal truth perspective, would it
20 be fair to say at that point, would it be
21 accurate to say that you didn't know why?
22 DR. COOK:
23 A. Well, we didn't know particularly where--I
24 mean, it wasn't one particular problem. I
25 mean, the issue where the test went wrong

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1 could vary from patient to patient, just
2 didn't know. I mean, you couldn't say looking
3 at the slides, say, where there was a
4 particular problem, a technical. You could
5 say if there was a problem with
6 interpretation, but that would vary from
7 individual to individual.
8 COFFEY, Q.C.:
9 Q. You say a problem with interpretation, does
10 that includes cases where, from your
11 perspective, based upon what you were seeing
12 on the original slide, in your view, the slide
13 shouldn't have been reported at all?
14 DR. COOK:
15 A. It's regarded where you may have an over-
16 interpretation where a pathologist was, say,
17 interpreting cytoplasmic stain as being
18 positive, that sort of thing.
19 COFFEY, Q.C.:
20 Q. What category then, from your perspective
21 would cases where the original slide that
22 you'd looked at in late July, historic
23 original slide, you were telling the
24 Commissioner yesterday that in some instances,
25 based upon what you were seeing, you didn't

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1 think that the pathologist should have
2 reported because, for example, the internal
3 controls hadn't stained. What category would
4 they fall into?
5 DR. COOK:
6 A. Well, they would be invalid.
7 COFFEY, Q.C.:
8 Q. And would that fall into an interpretive
9 error?
10 DR. COOK:
11 A. It could, yes.
12 COFFEY, Q.C.:
13 Q. In the sense that there shouldn't have been an
14 interpretation of the slide at all except to
15 say, I can't report it.
16 DR. COOK:
17 A. That's correct.
18 COFFEY, Q.C.:
19 Q. Exhibit P-0556. Doctor, this is a letter and
20 I gather it's a draft of a letter of August 5,
21 2005, it's addressed to Dr. Williams and it's
22 prepared for your signature.
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. And there's some handwriting as well. It's
2 typed and then there's some handwriting on it,
3 some changes. This is your handwriting?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And this relates to--and you begin by saying,
8 both Dr. Dan Fontaine and myself met with
9 Heather Predham today to discuss the issue of
10 technologists and their interaction with
11 pathologists in regards to immunoperoxidase
12 staining. Following that discussion I would
13 like to make the following recommendations",
14 and then you list out a number of them and
15 some of them, you've obviously been redrafting
16 this letter, the original text. Doctor, did
17 this or any version of this letter ever get
18 sent?
19 DR. COOK:
20 A. I can't remember, Mr. Coffey, probably not.
21 This must have been my thoughts at the time
22 and if I hadn't sent it, I would have
23 communicated those thoughts to Dr. Williams in
24 various discussions.
25 COFFEY, Q.C.:

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1 Q. I'm sorry, you would have communicated what is
2 here verbally to him anyway, at one time or
3 another -
4 DR. COOK:
5 A. Yes, because this was sort of the thought
6 process that was going on at the time.
7 COFFEY, Q.C.:
8 Q. And here then, you've noted the, suggesting,
9 making the recommendation, "the establishment
10 of a separate immunoperoxidase service of at
11 least three technologists solely dedicated to
12 immunoperoxidase staining. These
13 technologists must be trained in a major
14 immuno referral lab that has well established
15 quality control and troubleshooting program.
16 DR. COOK:
17 A. Um-hm.
18 COFFEY, Q.C.:
19 Q. So, the idea of three technologists solely
20 dedicated to this, that idea, in fact, dates
21 to May, doesn't it, if not before?
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. May 24, your May 24th letter.

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1 DR. COOK:
2 A. I was thinking about that May 24th, yes.
3 COFFEY, Q.C.:
4 Q. And that idea, in fact, had surfaced at some
5 points in the past in terms of the idea of
6 dedicated technologists going back to Dr.
7 Ejeckam's memos.
8 DR. COOK:
9 A. Right.
10 COFFEY, Q.C.:
11 Q. And June memo of '03.
12 DR. COOK:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. The idea that the technologists or any such
16 technologists be trained at a major immuno
17 referral lab, to you knowledge, even to this
18 day, has that been done?
19 DR. COOK:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. The technologists that are working at Eastern
23 Health now in the IHC lab -
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. - have been trained at a major lab?
3 DR. COOK:
4 A. Well, they've been trained--if you're
5 referring to what we had referring those
6 individuals to Montreal Jewish General and
7 Mount Sinai, that's what I'm referring to.
8 COFFEY, Q.C.:
9 Q. So, the training you were thinking of here
10 was, at that point, were you contemplating,
11 like, several days or several weeks or months
12 or did you have any -
13 DR. COOK:
14 A. In the ballpark figure of about weeks to
15 months at a lab such as Mount Sinai or
16 Montreal Jewish General.
17 COFFEY, Q.C.:
18 Q. I take it, in your reference here, "that has
19 well established quality control and
20 troubleshooting program would involve such
21 technologists being exposed to those programs
22 on a continuous basis.
23 DR. COOK:
24 A. Yes, I was looking more for Mount Sinai to
25 that.

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1 COFFEY, Q.C.:
2 Q. Second paragraph, you say, "to identify highly
3 motivated, enthusiastic individuals preferably
4 currently training in the College of the North
5 Atlantic and secure these individuals full
6 time employment in the immunoperoxidase
7 service with job guarantee, appropriate
8 remuneration and further training". Doctor,
9 what were thinking of there?
10 DR. COOK:
11 A. I was thinking of looking ahead. In our
12 organization right now, individuals,
13 technologists, whoever, are put ahead on the
14 basis of seniority and I'm not too sure that
15 I--I'm not particularly happy with that. I
16 would like to see people put in positions who
17 have the appropriate qualifications and know
18 how to run, for instance, a highly complex
19 service such as immunoperoxidase. So, the
20 best individuals I was looking at were
21 individuals just coming out of the College of
22 the North Atlantic, young people whom you can
23 train and whom would be around for quite some
24 time within your organization.
25 COFFEY, Q.C.:

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1 Q. Now Doctor, you express that thought, I take
2 it, at one or more times to Dr. Williams?
3 DR. COOK:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. Has there been any movement in that regard?
7 DR. COOK:
8 A. I haven't seen much movement. That would
9 require major negotiations with the various
10 unions and their contracts to deal with that.
11 COFFEY, Q.C.:
12 Q. There's a paragraph here, "hiring of at least
13 three pathology assistants" and you refer to
14 these individuals can be identified from
15 College of North Atlantic and trained to
16 perform standardized grossing and cutting
17 techniques". The pathology assistants, we've
18 seen references to that going back over the
19 years and I think back to Dr. Robb's time
20 perhaps or -
21 DR. COOK:
22 A. Well, it went back to first of all, the Hay
23 Report of '02, my annual review of '03, Dr.
24 Robb's letter of '04.
25 COFFEY, Q.C.:

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1 Q. Yes. All of which were in favour of the idea
2 of pathology assistants.
3 DR. COOK:
4 A. That's correct.
5 COFFEY, Q.C.:
6 Q. And I take it that there has been some
7 movement in that regard since August of 2005?
8 DR. COOK:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. And they're in the process of doing that now?
12 DR. COOK:
13 A. Yes, we have pathology assistants.
14 COFFEY, Q.C.:
15 Q. Pathology assistants now. The pathology
16 assistants then positions were only
17 established after the ER/PR matter arose in
18 2005.
19 DR. COOK:
20 A. That's correct.
21 COFFEY, Q.C.:
22 Q. Doctor, do you have any reason to believe that
23 there would be--if the ER/PR matter hadn't
24 arisen in 2005, do you have any reason to
25 believe that there'd be pathology assistants

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1 today?
2 DR. COOK:
3 A. I don't think there would be pathology
4 assistants today.
5 COFFEY, Q.C.:
6 Q. You are referencing here or recommending
7 "establishment for quality assurance or
8 proficiency testing program for the
9 immunoperoxidase service".
10 DR. COOK:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. So, and I take it you also refer to that in
14 your May 24th letter?
15 DR. COOK:
16 A. Yes, some of this were my thoughts that I was
17 putting down in that letter just rehashing
18 some various things.
19 COFFEY, Q.C.:
20 Q. On the next page, I'm sorry, I'll take you to
21 is, paragraph six, you encourage recruitment
22 of young technologists into the program
23 because of the retirement -
24 DR. COOK:
25 A. That's what I was looking for, yes.

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1 COFFEY, Q.C.:
2 Q. And you're looking for appropriate CME funding
3 for our immunotechnologists.
4 DR. COOK:
5 A. Um-hm.
6 COFFEY, Q.C.:
7 Q. I take it, was there any, up to that point?
8 DR. COOK:
9 A. There was a small amount of funding Mr.
10 Gulliver had for technologists in general, a
11 very small amount, so he would decide each
12 year, select maybe two or three technologists
13 to go up on various CME activities, but
14 nothing, nothing significant for all our
15 technologists in general and nothing,
16 certainly, significant for immuno
17 technologists, in particular.
18 COFFEY, Q.C.:
19 Q. Do you know if that has changed?
20 DR. COOK:
21 A. I believe we have increased CME funding in
22 that area.
23 COFFEY, Q.C.:
24 Q. You conclude by, your draft of the letter by
25 saying how, "I'd like to end by saying that

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1 over the past--last five years there has been
2 a lot of emphasis placed on utilization
3 management and living with our budgets. The
4 emphasis now is to be placed on quality
5 assurance with the additional human and
6 financial resources this requires."
7 DR. COOK:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. Now, Doctor, at the time, I take it, in
11 August, 2005 that was your honestly held view
12 of the situation?
13 DR. COOK:
14 A. Yeah, it was.
15 COFFEY, Q.C.:
16 Q. Has anything since then happened to change
17 your view in that regard?
18 DR. COOK:
19 A. Yes, there is more emphasis now towards
20 quality assurance, certainly amongst many
21 people within Eastern Health and certainly
22 amongst our administrative individuals that
23 there is a greater focus on quality assurance.
24 COFFEY, Q.C.:
25 Q. Exhibit P-0081, please? And, Doctor, this is

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1 a letter to yourself and Dr. Williams, it's
2 dated August 8th, 2005, it's from Beverley
3 Carter, or Dr. Carter. And she writes,
4 "Following are, to the best of my current
5 knowledge, the figures I have compiled with
6 respect to estrogen receptor and progesterone
7 receptor testing for cases seen at the Health
8 Care Corporation of St. John's in 2002." And
9 then she lists out a number of numbers,
10 negative rates, conversion rates, and the
11 denominator she's using here is 87. I
12 apologize, the numerator. She says, "The
13 number of patients undergoing ER testing at
14 the Health Care Corporation of St. John's is
15 189 and the figure above," she says, "patients
16 identified as ER negative using a ten percent
17 cutoff or other surrogate markers" is 87. So
18 87 over 189 is a 46 percent negative rate, and
19 that's for 2002, the Health Care Corporation
20 cases. And "Of the 87 cases 18 have not been
21 retested. Of the 69 retested, 43 have
22 converted." Read by Dr. Carter and yourself
23 using the Ventana, which is a 62 percent
24 conversion rate. 43 over 69. And she then
25 calculates using a 62 percent conversion rate.

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1 Of all 87 negatives she calculates 17.5
2 percent true negative rate using the Ventana.
3 And she concludes by saying, "From these very
4 preliminary and very raw numbers I believe the
5 idea that the DAKO system, both its
6 performance and interpretation, greatly under
7 estimated the number of women who would
8 benefit from hormonal manipulation of their
9 breast cancer and should be investigated.
10 From these numbers it would also appear the
11 Ventana system is over estimating the number
12 of patients who are ER positive. Couple this
13 finding with the recent 60 percent
14 disagreement with Mount Sinai Hospital on
15 crude progesterone status, positive versus
16 negative and not percentile staining, and it
17 appears that we have another system that needs
18 investigating." So I take it the other system
19 is the Ventana system?
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Do you know if any further investigation was
24 done of the Ventana system?
25 DR. COOK:

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1 A. I can't recollect, Mr. Coffey.
2 COFFEY, Q.C.:
3 Q. And, Doctor, do you know how or why it was
4 that Dr. Carter came to write this letter?
5 DR. COOK:
6 A. Well, she had concerns over the sensitivity of
7 the Ventana, whether we were actually picking
8 up more, more positives on the Ventana than
9 the other system, in other words, were we
10 getting into the realm of false positives.
11 COFFEY, Q.C.:
12 Q. And that's why she wrote the letter?
13 DR. COOK:
14 A. Yes, that's my understanding why.
15 COFFEY, Q.C.:
16 Q. Was there anything further done after you
17 received this letter in relation to it?
18 DR. COOK:
19 A. I may have spoken to her regarding that and
20 this was--we still had the belief that if we
21 were going to retest, we were going to retest
22 all the Ventana system tests for the '04 and
23 '05 year.
24 COFFEY, Q.C.:
25 Q. And retest the negatives and the positives?

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1 DR. COOK:
2 A. Positives, that was the initial thinking.
3 COFFEY, Q.C.:
4 Q. Did the positives ever get retested?
5 DR. COOK:
6 A. The positives never got retested.
7 COFFEY, Q.C.:
8 Q. Why is that?
9 DR. COOK:
10 A. Well, at that particular period of time we
11 were--when we were sending the cases up to
12 Mount Sinai, Mount Sinai were having capacity
13 problems with trying to do all the retests,
14 and I believe we made a decision, primarily, I
15 think, Dr. Williams made a decision that for
16 now we would hold off the retesting on the
17 positive DAKO--correction, Ventana systems
18 mainly due to capacity problems that Mount
19 Sinai was experiencing at the time.
20 COFFEY, Q.C.:
21 Q. Did the subject matter ever arise again?
22 DR. COOK:
23 A. It may--I remember it may arose near the end
24 of the review process.
25 COFFEY, Q.C.:

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1 Q. And what happened then?
2 DR. COOK:
3 A. Well, the feeling was, when we looked at the
4 number of retro converters from the selected
5 cases, the negative cases that we had in the
6 review, the number of cases were actually very
7 small, but that was a selective group. What
8 was felt at the time when we reviewed the ER
9 and PR issue that the major problem with ER
10 and PR was the false negative rate as opposed
11 to a false positive rate. So the decision was
12 made, and I believe it may have been a
13 consensus manner, that at the time we would
14 not go ahead and retest all specimens, I mean,
15 from the Ventana system as well as the other
16 positives that we had from the DAKO.
17 COFFEY, Q.C.:
18 Q. And consensus amongst whom?
19 DR. COOK:
20 A. I think that would have been myself, Heather
21 Predham, Nash Denic was there at the time, I
22 believe Dr. Williams was there at the time. I
23 can't remember if there was anybody--oh, some
24 of their oncologists were there, Dr. Laing, I
25 believe. So we made that decision based on

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1 the, what we thought was the major problem
2 with the testing, the false negatives as
3 opposed to false positives.
4 COFFEY, Q.C.:
5 Q. And approximately when would that have been?
6 DR. COOK:
7 A. Oh, that would have been made sometime, I
8 believe, around the spring of '06.
9 COFFEY, Q.C.:
10 Q. Exhibit P-0560, please? Doctor, this is a
11 memo from yourself to all pathologists in
12 Eastern Health and Mr. Dyer, Gulliver and Dr.
13 Williams, August 8th, 2005. The subject is
14 "Estrogen receptor and progesterone receptors
15 on current cases." And I take it this is a
16 memo outlining what is to be done in relation
17 to henceforth there being a hold on the
18 reporting of ERs and PRs by pathologists in
19 Eastern Health? I take it that's -
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. - this paragraph. And this proposal to have,
24 well, ERs and PRs to be forwarded to Mount
25 Sinai for IHC processing and reporting?

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. Reports would be returned to Dr. Carter and
5 released into the hospital information system.
6 I take it that means being entered, dictated
7 somehow into the -
8 DR. COOK:
9 A. That's the computer, Meditec system.
10 COFFEY, Q.C.:
11 Q. "Hard copies of these reports will be
12 forwarded to the appropriate physician. All
13 pathologists will continue to order ERs and
14 PRs on their respective cases, fill out the
15 IHC request form and forward this to the
16 technologist. The ER/PR IHC stain will
17 simultaneously be processed by our
18 technologists and sent back to the ordering
19 pathologist and once these stains are received
20 the ordering pathologist will give an
21 interpretation using the enclosed form and
22 forward that to Dr. Carter."
23 DR. COOK:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. And that report or "This report is not to be
2 released within the hospital information
3 system." So that's the process you described
4 to the Commissioner earlier?
5 DR. COOK:
6 A. That's correct. We're looking at doing a
7 correlation between our interpretations and
8 Mount Sinai with the view when we restarted
9 the ER and PR, we were looking at general list
10 sign out.
11 COFFEY, Q.C.:
12 Q. And it went sofar as to actually be sent out
13 in a memo?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Formalized. Exhibit P-0561, please? Doctor,
18 this is again a memo to all pathologists in
19 Eastern Health, Dr. Williams, Mr. Dyer and Mr.
20 Gulliver from yourself, August 8th, 2005. ER
21 and PR on cases from May, '97 to August 9th,
22 2005. And you write, "Cases from May, '97 to
23 March 31, 2004 that are ER negative except
24 those from patients who are deceased will be
25 referred to Mount Sinai."

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. "The paraffin block that the ER and PR was
5 originally performed on will be forwarded to
6 Mount Sinai for repeat testing. Once the
7 Mount Sinai report has been received at the
8 St. Clare's site an addendum will be issued by
9 Dr. Cook or Dr. Carter in the hospital
10 information system. This applies to all cases
11 that are ER negative on a primary breast
12 lesion independent of PR status, ER negative
13 being defined as ten percent or less." And
14 then "All ER and PRs performed on the Ventana
15 system from April 1, 2004 to August 9th, 2005
16 will be referred to Mount Sinai as above."
17 Now, Doctor, some questions on this. Well,
18 first of all, was this sent out, do you think?
19 DR. COOK:
20 A. I would assume that it was, yes.
21 COFFEY, Q.C.:
22 Q. Oh, yes. Now, I'm just--and it certainly does
23 have the vice president's -
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. - office's stamp. Now, here, Doctor, why May,
3 '97 to March 31, 2004?
4 DR. COOK:
5 A. That was information that was given to me from
6 Mr. Gulliver as to when we had the start up of
7 the ER and PR on the DAKO system.
8 COFFEY, Q.C.:
9 Q. That's the May, '97 date?
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. March 31, 2004 date?
14 DR. COOK:
15 A. That was when we discontinued the DAKO
16 staining and started the Ventana operation.
17 And that, again, would have been information
18 given to me by Mr. Gulliver.
19 COFFEY, Q.C.:
20 Q. Now, in terms of what ER negative is, if we
21 look at paragraph 4 it says, "This applies to
22 all cases that are ER negative on the primary
23 breast lesion, independent of PR status. ER
24 negative being defined as ten percent or
25 less."

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Where did the ten percent come from?
5 DR. COOK:
6 A. That was probably in relation to the study or
7 I was using at that time the ten percent
8 cutoff that study that Dr. Carter was doing.
9 I did realize or I may have realized at that
10 time that we were using a 30 percent cutoff
11 that the oncologists were interpreting. This
12 was more, this was more of a clinical
13 interpretation as opposed to a lab
14 interpretation as to the cutoff.
15 COFFEY, Q.C.:
16 Q. So, I'm sorry, which is the clinical
17 interpretation?
18 DR. COOK:
19 A. The ten percent.
20 COFFEY, Q.C.:
21 Q. Ten percent?
22 DR. COOK:
23 A. Yeah. And I probably at that point didn't
24 realize that we were using or the oncologists
25 were using the 30 percent.

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1 COFFEY, Q.C.:
2 Q. Were using -
3 DR. COOK:
4 A. So for all intents and purposes I should have
5 put in that 30 percent there.
6 COFFEY, Q.C.:
7 Q. Now, Doctor, you do say in paragraph 5 that
8 "All ERs and PRs performed on the Ventana
9 system from April 1, 2004 to August 9th, 2005
10 will be referred to Mount Sinai as above." So
11 the point was all ER and PRs, whether positive
12 or negative?
13 DR. COOK:
14 A. Yeah, that was -
15 COFFEY, Q.C.:
16 Q. At that point?
17 DR. COOK:
18 A. - the thinking at the time, yes.
19 COFFEY, Q.C.:
20 Q. The Ventana we're going to--done on the
21 Ventana system in St. John's were going to be
22 sent to Mount Sinai?
23 DR. COOK:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. So, Doctor, did any of this then--well, we
2 know that the paragraph 5 changed, because
3 you've told us that.
4 DR. COOK:
5 A. Yeah.
6 COFFEY, Q.C.:
7 Q. It got limited to the ER negatives on the
8 Ventana system. But what about this ten
9 percent, how did that work itself out?
10 DR. COOK:
11 A. Well, that changed after I had a discussion
12 with Dr. Kara Laing in her office on August
13 the 10th where I was trying to or trying to
14 determine what oncologists were interpreting
15 as cutoff points, and in that discussion they
16 were using 30 percent or less up until, I
17 believe, the end of December of 2000. And
18 following that, starting in January of--up to
19 December of '99 and then from January of 2000,
20 I believe, they were using a cutoff of ten
21 percent or less, clinical cutoff.
22 COFFEY, Q.C.:
23 Q. If we could, Exhibit P-0942? Doctor, this is
24 an office copy, I take it, because you got
25 that little check mark there. That check mark

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1 in your practice means what?
2 DR. COOK:
3 A. That memo would have been signed and released.
4 COFFEY, Q.C.:
5 Q. Okay. So and this is your--this would be a
6 copy, your office copy?
7 DR. COOK:
8 A. Office copy.
9 COFFEY, Q.C.:
10 Q. Okay. And this is the August 8th, 2005 memo
11 to all pathologists on the--advising in St.
12 John's and Dr. Williams and Mr. Dyer and Mr.
13 Gulliver of the retrospective retesting?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. This is the one. If we look down here on the
18 right-hand side, that's your handwriting?
19 DR. COOK:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Okay. So, Doctor, perhaps does that assist
23 you, then, here you've written "2001, ten
24 percent."
25 DR. COOK:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. And then you've got "2000 and '99" with an
4 arrow to '97.
5 DR. COOK:
6 A. Right.
7 COFFEY, Q.C.:
8 Q. "Cutoff less than 30 percent"?
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And then you've written, "Spoke to Dr. Laing,
13 August 10th, 2005 regarding this."
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. And then "January, 2001 onward, oncologist
18 decision to use ten percent as cutoff." And
19 "Patient treated by radiation oncologists in
20 '99, 2000 area."
21 DR. COOK:
22 A. Right.
23 COFFEY, Q.C.:
24 Q. So what was the last comment about, do you
25 recall that?

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1 DR. COOK:
2 A. Oh, that last comment, again, referred to the
3 oncology shortage that we had around 2000, and
4 there was a shortage of medical oncologists
5 and they were being treated with radiation
6 oncologists.
7 COFFEY, Q.C.:
8 Q. So these are your notes made of that August
9 10th meeting with Dr. Laing?
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. So up to December 31, 2000, the day before
14 January 1, 2001?
15 DR. COOK:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. It would be less than 30 percent?
19 DR. COOK:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. And then beginning January, 2001, January 1st,
23 2001 onward, ten percent was used as the
24 cutoff here?
25 DR. COOK:

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1 A. That's correct. And these are, I mean, there
2 could be variation. I mean, you might have
3 variations in cutoffs by individual
4 oncologists, but this was sort of a cutoff
5 point that we were using.
6 COFFEY, Q.C.:
7 Q. And on that point, Doctor, I wanted to take
8 that up with you because, for example, if an
9 oncologist in, say, March of 2001, a
10 particular oncologist, March, 2001, was
11 utilizing, still utilizing a 30 percent
12 cutoff?
13 DR. COOK:
14 A. Um-hm.
15 COFFEY, Q.C.:
16 Q. And in this review if a patient had an ER of
17 20 percent in March, 2001, would that patient
18 have been retested?
19 DR. COOK:
20 A. No, that patient would have fell out of the
21 criteria.
22 COFFEY, Q.C.:
23 Q. Despite the fact that the individual
24 oncologist might have actually, back in March,
25 2001, treated the patient as being negative?

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1 DR. COOK:
2 A. Possible, yes.
3 COFFEY, Q.C.:
4 Q. And this January 1, 2001 date, how hard and
5 fast were you given to understand that was?
6 DR. COOK:
7 A. It wasn't hard and fast. I mean, it was a
8 point that we agreed upon that we would use as
9 criteria. When we got into the panelling
10 process there were oncologists who were
11 treating at five percent, 15 percent, 20
12 percent, so it was a cutoff that we had used
13 as criteria for the panelling process which
14 involved our oncologists and surgeons and
15 ourselves.
16 COFFEY, Q.C.:
17 Q. Was any thought give, Doctor, to just simply
18 using 30 percent as the cutoff for all
19 retesting?
20 DR. COOK:
21 A. No.
22 COFFEY, Q.C.:
23 Q. Okay. The idea of--because I take it there
24 was never any suggestion any oncologist was
25 using more than 30 percent -

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1 DR. COOK:
2 A. No, that I can remember.
3 COFFEY, Q.C.:
4 Q. Okay. So but by adopting some standard like
5 that, one would have picked up for retest then
6 anybody who conceivably could have been
7 characterized years ago as negative? Take in
8 2001, what I'm getting at is in 2001, the
9 spring of 2001, if there were straggles
10 amongst the oncologists still utilizing 30
11 percent, they would -
12 DR. COOK:
13 A. It's possible, yes.
14 COFFEY, Q.C.:
15 Q. They would have been picked up. But anyway,
16 there was no thought given to it?
17 DR. COOK:
18 A. No, it didn't come up for discussion.
19 COFFEY, Q.C.:
20 Q. Exhibit P-0559, please? Doctor, just before I
21 forget, having been so apprised on August 10th
22 of that by Dr. Carter, did you do anything
23 then to change the criteria?
24 DR. COOK:
25 A. You mean -

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1 COFFEY, Q.C.:
2 Q. To factor in this 30 percent?
3 DR. COOK:
4 A. Apprised by Dr. Carter -
5 COFFEY, Q.C.:
6 Q. See, well--and I apologise, Dr. Carter. Dr.
7 Laing, I apologise. On August 10th you met
8 with Dr. Laing -
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And you've told us about that, and she
13 mentioned the 30 percent back in '98 through -
14 DR. COOK:
15 A. Right.
16 COFFEY, Q.C.:
17 Q. - the end of 2000, and you, in your memo of
18 August 8th, initially had been thinking well,
19 ten percent.
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Going all the way back. Did you then
24 communicate this difference in utilizing 30
25 percent?

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1 DR. COOK:
2 A. Not to the pathologist. I would have
3 indicated that to our technologists who were
4 sequestering in the blocks of slides. That
5 would have been Mr. Gulliver and Mr. Dyer.
6 COFFEY, Q.C.:
7 Q. And now in terms of the technologists, this is
8 a signed copy of a memo of August 8th 2005 to
9 Mr. Gulliver and Mr. Dyer and Ms. Butler, Mary
10 Butler, Ken Green and Les Simms.
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. I take it that Ms. Butler, Mr. Green and Mr.
15 Simms were mentioned here because they are the
16 three who were doing ER and PR staining?
17 DR. COOK:
18 A. That's correct.
19 COFFEY, Q.C.:
20 Q. And subject is "estrogen receptors,
21 progesterone receptors. There will be a hold
22 on reporting of all ERs and PRs by all
23 pathologists. The IHC form will continue to
24 be filled out by our pathologists. Upon
25 receipt of the immunohistochemical form, fax a

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1 copy to Dr. Carter at St. Clare's. We will
2 continue to proceed with requests and return
3 stained ER and PR slides using the Ventana
4 system to the ordering pathologist. Following
5 this, the same paraffin block will be
6 forwarded to Dr. Carter at St. Clare's. Dr.
7 Carter will forward the paraffin blocks to
8 Mount Sinai with the standardized request.
9 The Mount Sinai report with the slides and
10 paraffin block will be returned to the St.
11 Clare's site."
12 DR. COOK:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. So I take it this was your method of getting
16 the technologists in the loop, as it were, on
17 this parallel processing?
18 DR. COOK:
19 A. That's correct.
20 COFFEY, Q.C.:
21 Q. And the second page of this exhibit, I take it
22 this is your handwriting here next to
23 paragraph five?
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. You have written here "with a note requesting
3 what is ordered. If slides are also sent,
4 please attach a note stating what is ordered,"
5 and you got September 29th '05.
6 DR. COOK:
7 A. Um-hm.
8 COFFEY, Q.C.:
9 Q. See that? What was this note about? Who was
10 it to and why was it sent September--or why
11 did you make it September 29th?
12 DR. COOK:
13 A. "With a note requesting what is ordered. If
14 all slides are also sent, please attach a
15 note" I can't remember exactly what that
16 refers to, Mr. Coffey.
17 COFFEY, Q.C.:
18 Q. Because it's around the time that you've
19 indicated that you had the conversation in
20 October of '05 with someone about the fact
21 that the slides were not being stained. Like
22 this is September 29th -
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. - and you said it is October you recall that
2 you first found out the slides were not, in
3 fact, being stained.
4 DR. COOK:
5 A. I can't be absolutely sure on that.
6 COFFEY, Q.C.:
7 Q. Okay.
8 THE COMMISSIONER:
9 Q. Mr. Coffey, wherever you can find a point for
10 the break.
11 COFFEY, Q.C.:
12 Q. Thank you, Commissioner. If we could, please,
13 Exhibit P-0557? These are some notes, Doctor,
14 of again Dr. Williams of meetings, but first
15 of all, it's yourself, him and Mr. Gulliver,
16 and there's a note on the fourth or fifth
17 bullet that you are about to or you plan to
18 speak to Dr. Laing re: how cases were treated
19 based upon degree of positivity.
20 DR. COOK:
21 A. Right.
22 COFFEY, Q.C.:
23 Q. "Check list to see who is alive." Whose
24 responsibility was it to identify the deceased
25 patients?

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1 DR. COOK:
2 A. That was Heather Predham.
3 COFFEY, Q.C.:
4 Q. Next bullet says "all blocks will be pulled
5 and then Dr. Cook and Dr. Fontaine will review
6 blocks and will send in one big package."
7 What was--"it will be next week before blocks
8 sent off. Three to four weeks for retesting."
9 Now Doctor, the idea of yourself and Dr.
10 Fontaine, what were you going to be doing
11 here?
12 DR. COOK:
13 A. Well, I would be reviewing the blocks and
14 slides from the Grace and St. Clare's and Dr.
15 Fontaine would be reviewing the slides from
16 the General Hospital site, and this was to do-
17 -we would look at the histology, confirm that
18 there's tumour there, verify that the original
19 ER and PR was ordered on a particular block,
20 and that block from which the initial order
21 request was made would be referred to Mount
22 Sinai.
23 COFFEY, Q.C.:
24 Q. So you'd be doing it for the blocks from two
25 original hospital sites and Dr. Fontaine was

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1 going to do the others?
2 DR. COOK:
3 A. Just the General.
4 COFFEY, Q.C.:
5 Q. Done at the General, and I take it that would
6 be with a view to making sure you had the
7 appropriate blocks to be sent?
8 DR. COOK:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Okay. It says here "will be next week before
12 the blocks sent off," fine, and then it says
13 "three to four weeks for retesting."
14 DR. COOK:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. What was the basis for that?
18 DR. COOK:
19 A. That would be--I mean, that would have been my
20 discussions I had with Maria Mendes. I
21 probably would have had discussions with her
22 or with Ken Pritzker regarding the turnaround
23 times for the cases.
24 COFFEY, Q.C.:
25 Q. And for the retesting cases?

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1 DR. COOK:
2 A. I believe the retesting.
3 COFFEY, Q.C.:
4 Q. Now when you were discussing that with them,
5 what, if anything, did you tell them about the
6 sheer number of cases?
7 DR. COOK:
8 A. Well, when I spoke to Maria Mendes, the number
9 that I had was about 500-550. That was the
10 number given to me, an approximate from Mr.
11 Gulliver.
12 COFFEY, Q.C.:
13 Q. Did you pass that on to her?
14 DR. COOK:
15 A. Maria Mendes?
16 COFFEY, Q.C.:
17 Q. Yes.
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And when was that, do you recall?
22 DR. COOK:
23 A. Maybe sometime in August, maybe early
24 September. It's in my notes.
25 COFFEY, Q.C.:

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1 Q. Okay, and she told you what, that it would
2 take how long?
3 DR. COOK:
4 A. I think until the end of September, I believe.
5 That was approximate time period.
6 COFFEY, Q.C.:
7 Q. Now did that only include the St. John's cases
8 at that point?
9 DR. COOK:
10 A. I can't be sure, maybe, Mr.--I can't be
11 absolutely sure on that.
12 COFFEY, Q.C.:
13 Q. Because it's about 500, St. John's is about
14 half the province, so -
15 DR. COOK:
16 A. Yeah, I think at that time it may be an
17 estimate of the total Newfoundland population.
18 I mean, I can't be absolutely sure.
19 COFFEY, Q.C.:
20 Q. Okay, and the third last bullet notes that
21 "maybe one and a half to two months to get all
22 the reports done."
23 DR. COOK:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. And one and a half to two months, what does
2 this mean, refer to?
3 DR. COOK:
4 A. That probably would have been the 500 or 550
5 we were talking about.
6 COFFEY, Q.C.:
7 Q. Get them ready to go?
8 DR. COOK:
9 A. Will have the stains done and reports back to
10 us.
11 COFFEY, Q.C.:
12 Q. And if I could, Commissioner, just before we
13 break, there's another note here of Dr.
14 Williams. It's undated, but it refers to "Dr.
15 Cook and myself," that would be Dr. Williams,
16 "talked with Dr. Laing," and I take it this is
17 referring to "prior to 2000, ER/PR negative,
18 post-menopausal women got Tamoxifen anyway.
19 This practice changed in 2002" and then "of
20 women who test positive, most are ER positive
21 and PR positive, less are ER positive and PR
22 negative. Five to ten percent are ER negative
23 plus PR positive. It was felt this number is
24 now less than five to ten percent."
25 So who was providing this information

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1 about what's to be expected, in terms of how
2 many would test ER negative and PR positive?
3 DR. COOK:
4 A. That was coming from Dr. Laing, I believe.
5 COFFEY, Q.C.:
6 Q. And as of that point, which would be--I gather
7 this is probably August, sometime in August
8 2005, was there any focus on the fact that in
9 the past, a number of patients had tested ER
10 negative and PR positive in St. John's?
11 DR. COOK:
12 A. I can't be absolutely sure on that. I mean,
13 there may have been.
14 COFFEY, Q.C.:
15 Q. Because it arises here.
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. It's brought up at a meeting and Dr. Laing
20 provides this information, statistic,
21 suggesting that perhaps less than five to ten
22 percent of people would be ER negative and PR
23 positive.
24 DR. COOK:
25 A. ER negative and PR positive, yes.

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1 COFFEY, Q.C.:
2 Q. And yet, we now know that there are quite a
3 number.
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. From this area that originally tested that
8 way.
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. I'm wondering, did that arise at that time as
13 kind of an area of concern by the oncologists?
14 DR. COOK:
15 A. I can't be absolutely sure of how that figure
16 arose. I mean, I really can't, I can't say.
17 COFFEY, Q.C.:
18 Q. And before we leave this, the end of this note
19 says, second last bullet, "first list June
20 29th '04, 16 to 25 converted on Ventana. 10
21 of 16 were told. Of the six remaining, some
22 were dead and some were already treated." And
23 "the second list, July 18th, 2005, 25 of 32,
24 oncologists wish to have repeats from Mount
25 Sinai."

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. So I take it the oncologists wanted those in
5 the second grouping, the 25 to 32?
6 DR. COOK:
7 A. That's correct, and they -
8 COFFEY, Q.C.:
9 Q. Retested at Mount Sinai?
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Thank you, Commissioner.
14 THE COMMISSIONER:
15 Q. Take the morning break.
16 (RECESS)
17 THE COMMISSIONER:
18 Q. Please be seated. Mr. Coffey.
19 COFFEY, Q.C.:
20 Q. Thank you, Commissioner. Exhibit P-0941,
21 please? Now Doctor, this is an e-mail of
22 August 8th, 2005 from Heather Predham to Dr.
23 Williams, yourself and Mr. Gulliver and Ms.
24 Pilgrim and the subject is "overall database."
25 Doctor, during your involvement in this

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1 matter, did you ever have any concerns about
2 how complete the database was in terms of its
3 identifying all the people who were ER
4 negative?
5 DR. COOK:
6 A. Well, I think most of us or all of us had some
7 concerns whether we were going to capture all
8 the names. I mean, you're dealing with a
9 database that I would say is less than
10 perfect. I don't think there's 100 percent
11 guarantee that you're going to capture every
12 name. That was sort of the thinking that was
13 going around.
14 COFFEY, Q.C.:
15 Q. I take it at various points that was
16 discussed, the challenges were discussed?
17 DR. COOK:
18 A. Yes, there were significant challenges in
19 getting this together.
20 COFFEY, Q.C.:
21 Q. And from your perspective, I think earlier you
22 told us, Doctor, that in terms of the actual
23 identification of the patients, it was the
24 responsibility, from your perspective, of Ms.
25 Predham, combined with Mr. Gulliver and Mr.

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1 Dyer?
2 DR. COOK:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. That between them, they'd somehow accomplish
6 that?
7 DR. COOK:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. From your own perspective, Doctor, were you
11 ever actually personally satisfied or
12 comfortable that everybody had been
13 identified?
14 DR. COOK:
15 A. Pretty much, but always in the back of my
16 mind, I mean, as I said before, no system is
17 perfect and you can't absolutely guarantee
18 that 100 percent of those individuals will be
19 captured in the database.
20 COFFEY, Q.C.:
21 Q. And I take it, Doctor, that would be because
22 of your knowledge of the fact that this
23 involved numerous sites, at least three
24 different hospital sites originally?
25 DR. COOK:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Different computer systems.
4 DR. COOK:
5 A. That's correct, we were using -
6 COFFEY, Q.C.:
7 Q. You know, and just a whole bunch of different
8 criteria that it would be difficult to be
9 certain that you'd gotten everybody?
10 DR. COOK:
11 A. I would say that. I mean, this was an
12 unprecedented task that we had taken on, not
13 only here in St. John's but from across the
14 province as well.
15 COFFEY, Q.C.:
16 Q. Yes. And Doctor, here on this e-mail, there's
17 a reference to a hotline and it says "I'm
18 meeting with our staff re: the hotline and
19 what needs to be put in place. The biggest
20 thing from our perspective will be the answers
21 to the items identified in our script. We
22 will work on those today. Also, will be
23 informing GPs of this issue? I think Kara
24 Laing suggested that the letter use wording
25 like 'you will be notified by the physician

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1 following your cancer and an appointment made
2 to discuss results'" Now Doctor, I just refer
3 to this because I wanted to ask you about the
4 idea of notifying patients and what, if any,
5 input you had into that, notifying the public
6 or patients or physicians, and this happens to
7 be August 8th, and I gather the matter had
8 arisen before that?
9 DR. COOK:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. So looking back on it, from your perspective,
13 were you ever asked about your views on it,
14 for your own input?
15 DR. COOK:
16 A. Well, I was involved in some meetings and
17 committees regarding my view. My view at the
18 time was until we had all the information, we
19 had the scope and extent of the problem, and
20 we had the results back, that would be the
21 time to go public and disclose. So that was
22 my view that I put forward.
23 COFFEY, Q.C.:
24 Q. Now Doctor, did you envisage that you'd be
25 getting all the results back at one time?

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1 DR. COOK:
2 A. Well, it depended on how well we could send
3 the tissue off. I mean, if we sent the tissue
4 off at one time, I was envisioned that we
5 would get the results probably so many results
6 per week over a time period, as opposed to not
7 getting all the results at one time. So we
8 were sort of looking at, you know, 10 to 12--
9 you know, 10 to 20 cases per week and working
10 on those.
11 COFFEY, Q.C.:
12 Q. And what I'm getting at, Doctor, here is this,
13 and like now, certainly with the benefit of
14 hindsight, how realistic was it to think that
15 you could have 500 cases retested, get the
16 results back, notify the patients of the
17 results and then, and only then, tell the
18 public, without it becoming public in the
19 first place?
20 DR. COOK:
21 A. When I think in hindsight, we certainly had to
22 rethink that. I mean, that's hindsight, Mr.
23 Coffey.
24 COFFEY, Q.C.:
25 Q. And that's why I phrased it that way, Doctor,

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1 in terms of that. At the time that this was
2 discussed, I take it at some of the meetings
3 you attended, there was discussion of that
4 very issue?
5 DR. COOK:
6 A. Um-hm.
7 COFFEY, Q.C.:
8 Q. Whether to go public in the summer of 2005?
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And I understand that, we've heard evidence
13 that Dr. Laing certainly, on behalf of the
14 oncologists, voiced the view that it should
15 wait.
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Which is coinciding with what you just
20 expressed. Did anyone ever challenge--well,
21 first of all, I'll ask you, did you voice your
22 own view at those meetings?
23 DR. COOK:
24 A. I would voice my own view that until we knew
25 the scope and extent of the problem, and until

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1 we had the results back, we should wait.
2 COFFEY, Q.C.:
3 Q. Did anyone ever challenge you on--and say to
4 you, "Doctor, look, how realistic is that?
5 Because as soon as we begin to get results
6 back, we will tell patients, and as soon as we
7 tell the first 5, 10, 20, 30 patients, at some
8 point, it's going to go public and we're still
9 going to have hundreds more who don't have
10 results." So did anyone ever challenge you on
11 that?
12 DR. COOK:
13 A. I mean -
14 COFFEY, Q.C.:
15 Q. Or Dr. Laing, while you were there?
16 DR. COOK:
17 A. No. There was concerns from Dr. Williams. I
18 think he felt that we should go public
19 immediately. He voiced his concerns about
20 that. He was the only one that I can remember
21 expressing that. I mean, it was pretty well
22 consensus opinion from oncologists and
23 surgeons and administrative people, other
24 administrative people, to wait until we get
25 the results.

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1 COFFEY, Q.C.:
2 Q. They were administrative people within Eastern
3 Health?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And Doctor, you recall Dr. Williams expressing
8 the view, go public. I take it he--was he
9 saying go public because it's going to go
10 public anyway?
11 DR. COOK:
12 A. I think he wanted to go as public as quickly
13 as possible.
14 COFFEY, Q.C.:
15 Q. Yes, and in other words, before, I take it,
16 the results were back?
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. The idea of telling the physicians, what about
21 that? I mean, telling like GPs about the fact
22 that this is going on, telling the physicians
23 of Newfoundland. This is referred to here in
24 this, as of August 8th, 2005. The subject is
25 raised "also, will we be informing GPs of this

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1 issue?" So what was the view amongst the
2 physicians involved in this as to whether or
3 not GPs should be told?
4 DR. COOK:
5 A. I can't remember much discussion around that,
6 Mr. Coffey. I can't remember that being
7 discussed, if any, or to any detail.
8 COFFEY, Q.C.:
9 Q. If we could, please, Exhibit P-0562? Now this
10 is an e-mail of August 9th, 2005. It's to a
11 number of individuals, including yourself,
12 from Debbie Parsons. Who's Debbie Parsons?
13 DR. COOK:
14 A. I believe she's one of our--one of the
15 secretaries with QI.
16 COFFEY, Q.C.:
17 Q. And the subject is from Heather Predham re:
18 Dr. Carter's retesting results, and she says
19 "Hi, all. I have Dr. Carter's retesting
20 results entered in the database and have
21 summarized the results as attached" and she
22 makes reference to "I think I may be able to
23 get the Tamoxifen prescribed by MCP from
24 Pharmacy." Do you recall what this was about?
25 DR. COOK:

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1 A. I think there was an attempt to identify ER
2 and PR positive patients and trying to
3 determine how many got the Tamoxifen. It was
4 just a way of trying to determine how many
5 patients we have that were ER/PR positive. I
6 think that wasn't pursued further because she
7 couldn't really make that kind of correlation.
8 So I don't think that was pursued to any great
9 extent.
10 COFFEY, Q.C.:
11 Q. And the reference to Dr. Carter's retesting
12 results entered in the database, do you recall
13 which retesting results are we talking about
14 here and what database? And then she says--
15 I'll go to the next page, she says "I have
16 summarized the results as attached" and this
17 is the attachment.
18 DR. COOK:
19 A. Again, this may refer to the original testing
20 of 25 to 33 that we've had.
21 COFFEY, Q.C.:
22 Q. So the database referred to here, do you
23 recall what database this was at that point in
24 time?
25 DR. COOK:

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1 A. I can't recollect, Mr. Coffey.
2 COFFEY, Q.C.:
3 Q. Now, if we could, Exhibit, please, P-0564?
4 Now Doctor, this is Dr. Williams' notes of a
5 meeting of August 10th, 2005. Page five of
6 the exhibit is the typed version of it, and
7 it's a meeting on ER/PR receptors. There are
8 a number of individuals present, Mr. Tilley,
9 Dr. Laing, Ms. Pilgrim, yourself, Dr.
10 Williams, and you note here, at least the
11 reference here is that, in the fifth bullet,
12 it says--your update says "four to six weeks
13 for Mount Sinai to report these specimens."
14 DR. COOK:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. Which would suggest that it's going to take
18 you two weeks, in the bullet above, to get--
19 two weeks to get the blocks to Mount Sinai. I
20 take it these would be the St. John's blocks?
21 DR. COOK:
22 A. Most of those would be St. John's, I believe.
23 COFFEY, Q.C.:
24 Q. Well, at that point in time, I take it, there
25 were no other blocks in St. John's other than

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1 the St. John's blocks and the group sent by
2 Maurice Dalton at the end of June?
3 DR. COOK:
4 A. Yeah, the concentration initially was on the
5 St. John's cases.
6 COFFEY, Q.C.:
7 Q. So at that--as of August 10th, had the other
8 medical directors elsewhere in the province
9 even been asked to send?
10 DR. COOK:
11 A. I can't be sure of that, that specific date.
12 COFFEY, Q.C.:
13 Q. So the St. John's, at the earliest, was going
14 to be back by the end of September?
15 DR. COOK:
16 A. That's what we were looking at.
17 COFFEY, Q.C.:
18 Q. And then any other cases, there'd be a
19 corresponding delay, depending upon when they
20 got them to St. John's for retest--to be sent
21 to Mount Sinai for retesting?
22 DR. COOK:
23 A. There would have been a delay, yes.
24 COFFEY, Q.C.:
25 Q. So for example, if it was to take, I don't

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1 know, three weeks for Grand Falls to get their
2 material together and send it to St. John's,
3 it would have to be repackaged in St. John's,
4 collated and sent off to Mount Sinai, so you'd
5 be talking two to three months for other
6 hospitals outside St. John's to have their
7 material -
8 DR. COOK:
9 A. Depending how quickly they can get it into us,
10 you know. Again, I can't give an exact time
11 period with that.
12 COFFEY, Q.C.:
13 Q. Here, in the second last bullet, attributed to
14 your own comments, it says "all available
15 resources are being applied.
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Still doing a heavy workload ongoing."
20 DR. COOK:
21 A. That's right.
22 COFFEY, Q.C.:
23 Q. So you were bringing this to Dr. Williams and
24 Mr. Tilley's attention here?
25 DR. COOK:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Did you ever ask them for any other resources?
4 DR. COOK:
5 A. I was asking for more--in terms of resources,
6 we didn't have the available manpower. I
7 mean, if you were going to bring somebody into
8 the lab, you were going to have to train them
9 and first of all, to know how--where to
10 retrieve the various blocks and whatnot and in
11 terms of secretarial work, that would require
12 some training in terms of getting used to
13 various laboratory modules. What we were
14 primarily looking for in resources were
15 increased financial resources for overtime and
16 that sort of thing.
17 COFFEY, Q.C.:
18 Q. So did you obtain those?
19 DR. COOK:
20 A. We got the financial resources, like for
21 overtime for our secretaries and lab aides and
22 pulling out the various blocks and whatnot, I
23 believe, and most of that pulling of the
24 blocks were with--by Mr. Gulliver or Mr. Dyer.
25 COFFEY, Q.C.:

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1 Q. So I take it that you were given what
2 financial resources you requested?
3 DR. COOK:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. And I take it you're telling the Commissioner,
7 there wasn't really much point in looking for
8 more people because it would take a while even
9 to train them?
10 DR. COOK:
11 A. We would have to train them, yes, so it's come
12 as you are.
13 COFFEY, Q.C.:
14 Q. Here, under Heather Predham's update, the
15 last--fourth bullet says "first page shows
16 people who are on Tamoxifen," okay?
17 DR. COOK:
18 A. Um-hm.
19 COFFEY, Q.C.:
20 Q. And well, she said, the third bullet, "has a
21 list of all people who need to be retested."
22 The fourth bullet says "first page shows
23 people who are on Tamoxifen." Doctor, if it
24 was known that a particular patient was
25 already on Tamoxifen, what was the point of

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1 having their tissue sample retested?
2 DR. COOK:
3 A. I don't know what Ms. Heather--what Heather
4 Predham -
5 COFFEY, Q.C.:
6 Q. I'm just asking yourself. I mean, from your
7 perspective, in terms of this whole matter,
8 okay, certainly initially you didn't set out
9 to retest the deceased as a priority.
10 DR. COOK:
11 A. That's right.
12 COFFEY, Q.C.:
13 Q. Okay, there was, I mean, deal with the living
14 patients first.
15 DR. COOK:
16 A. Um-hm.
17 COFFEY, Q.C.:
18 Q. Okay. But even amongst the living patients,
19 if a patient was already on hormonal treatment
20 therapy, whatever the reason, then if their ER
21 was negative and it converted to positive, I
22 take it you would have envisaged that would
23 have no effect on their treatment anyway?
24 DR. COOK:
25 A. Well, I can't be absolutely sure about that.

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1 We had ER negative PR negative patients who
2 were given Tamoxifen by their physician for
3 various other reasons.
4 COFFEY, Q.C.:
5 Q. Yes, and I appreciate that. What I'm getting
6 at is if they were already on it, had already
7 been treated, if their ER came back from zero
8 to 50 and they were already being treated, you
9 would have understood it would probably make
10 no difference to the treatment because they
11 were already being treated.
12 DR. COOK:
13 A. Probably.
14 COFFEY, Q.C.:
15 Q. Correspondingly, for someone who was ER
16 negative, zero, and PR 50 already -
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. - what was--and they were on Tamoxifen because
21 of the PR 50 percent.
22 DR. COOK:
23 A. Right.
24 COFFEY, Q.C.:
25 Q. What was the point of retesting their ER

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1 status?
2 DR. COOK:
3 A. Because I--when I drew up the list and made
4 the criteria, I didn't know how the ER
5 negative PR positive patients were going to be
6 treated by a variety of oncologists over that
7 time period from '97 to '95 (sic). I simply
8 didn't know how 25 oncologists, over the
9 period of that time span, were treating these
10 patients. So I felt it would be safe to cast
11 as wide a net as possible. When we got these
12 results back, then we would look at these
13 results and the impact of the results on the
14 patients.
15 COFFEY, Q.C.:
16 Q. And so from your perspective, and you did
17 think it through, I take it, from the way
18 you've just described it then, at one point
19 you sat and thought you yourself "well, look,
20 I got so many oncologists. I can't really
21 tell." Some of whom will have moved on.
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. "I can't tell what criteria they would have

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1 used to treat or not treat patients in the
2 past, so to be certain, from my own
3 perspective," I, Dr. Cook's perspective, "if
4 it's ER negative, I will have it retested."
5 DR. COOK:
6 A. Yes, that was the criteria.
7 COFFEY, Q.C.:
8 Q. And if it converts, then we'll deal with it.
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Okay. As it turns out, Doctor, and the reason
13 I ask it is that as it turns out,
14 approximately 200 people were already on
15 Tamoxifen, you know, when we look at the
16 subsequent results.
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. Of those retested, about 200 were already, and
21 that's why, you know, the question would
22 arise, well, why retest them if they're
23 already on.
24 DR. COOK:
25 A. Well, I didn't have that information at the

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1 time, so I wanted to be safe rather than
2 sorry, try to catch as many people as we could
3 in the database.
4 COFFEY, Q.C.:
5 Q. Okay. Page six of this exhibit, if I could,
6 there are some remarks attributed to yourself,
7 where you say--this is attributed to you,
8 "there are deficiencies"--and I'm--actually,
9 I'm going to go back, if I could,
10 Commissioner, to the actual handwritten
11 version of this. It's page three. It says
12 "Dr. Cook, there are deficiencies" I don't
13 know if it's are or were, but "deficiencies in
14 our system re: communication, proficiency
15 testing, quality assurance, need QI -
16 MR. BROWNE:
17 Q. I think that should be person.
18 COFFEY, Q.C.:
19 Q. - person," probably, "for the lab."
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. So Doctor, here in discussing this at this
24 meeting of August 10th--I apologize, just go
25 back to the right page here, what were you

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1 referring to here? You're telling the people,
2 participants, what?
3 DR. COOK:
4 A. Well, we were identifying issues within the
5 lab regarding specifically ER and PR.
6 COFFEY, Q.C.:
7 Q. So what was it about communication then? It
8 says "re: communication," deficiencies re:
9 communication?
10 DR. COOK:
11 A. That may be, again, related to the management
12 structure, the organization that we had, the
13 flow through of information, I believe.
14 COFFEY, Q.C.:
15 Q. And the deficiencies in proficiency testing?
16 DR. COOK:
17 A. Well, we had no external proficiency testing
18 for ER and PR specifically.
19 COFFEY, Q.C.:
20 Q. And deficiencies in your system regarding
21 quality assurance?
22 DR. COOK:
23 A. Well, in regards to ER and PR. I didn't refer
24 to deficiencies in our overall quality
25 assurance activities, of which there were

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1 quite a few.
2 COFFEY, Q.C.:
3 Q. In terms of ER and PR, I take it -
4 DR. COOK:
5 A. But in terms of ER and PR.
6 COFFEY, Q.C.:
7 Q. And how about IHC itself?
8 DR. COOK:
9 A. Well, as I said earlier, there was no specific
10 QI program for IHC other than the fact that
11 they were included as part of the general
12 population when these cases were referred out
13 for review.
14 COFFEY, Q.C.:
15 Q. So the comment about deficiencies in the
16 system regarding communications, that would be
17 between the techs, technologists and the
18 pathologists generally, not just ER and PR?
19 DR. COOK:
20 A. Oh, overall.
21 COFFEY, Q.C.:
22 Q. Yes, and in particular, the IHC techs?
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. Proficiency testing would apply not only to ER
2 and PR, but IHC generally. There was no
3 particular proficiency testing for IHC?
4 DR. COOK:
5 A. No, other than proficiency testing for
6 pathologists and these external reviews.
7 COFFEY, Q.C.:
8 Q. And as well, the same comment would apply to
9 quality assurance?
10 DR. COOK:
11 A. Yes, for IHC.
12 COFFEY, Q.C.:
13 Q. Now sir, "need a QI person for the lab," it
14 says program there, but I take it would you
15 have recalled that you, in fact, were speaking
16 about a QI person for the lab?
17 DR. COOK:
18 A. That's right. We were getting into looking at
19 areas of concerns within the lab and I would
20 have been voicing the need for more resources
21 to be injected into the lab specifically in
22 the area of quality assurance and looking for
23 quality assurance coordinator.
24 COFFEY, Q.C.:
25 Q. And that would be for the lab at large?

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1 DR. COOK:
2 A. For the lab at large, at that time, yes.
3 COFFEY, Q.C.:
4 Q. And here it notes, "test all ER negatives less
5 than 30 percent, about 400 cases to be
6 tested." See that?
7 DR. COOK:
8 A. Yeah.
9 COFFEY, Q.C.:
10 Q. Here in the typed version, it's attributed to
11 yourself. Looking at the handwritten, it's
12 hard to tell. I'll just show you, if I could,
13 Doctor. I'm just going to show you, Doctor,
14 go to page six there. It's right there, but
15 when you actually look back at Dr. Williams'
16 handwritten notes, this is standing off to
17 itself. So was any thought or was this--I
18 asked you earlier about this, the idea of
19 perhaps testing all under 30 percent. Did
20 that come up as a topic?
21 DR. COOK:
22 A. No, Mr. Coffey, I can't remember that
23 specifically.
24 COFFEY, Q.C.:
25 Q. Okay, and then here, at the very bottom, and

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1 I'll go to the typed version, page six, it
2 notes "Mr. Tilley requested that we not wait
3 until we get all one batch. Can we make three
4 or four large batches?" So I take it that
5 was--you were agreeable to sending them off in
6 large batches?
7 DR. COOK:
8 A. Yeah.
9 COFFEY, Q.C.:
10 Q. And "what are key messages we should be
11 saying?" Did you have any input into that?
12 DR. COOK:
13 A. I mean, I would have been feeding information
14 into Dr. Williams as to the status of the
15 ER/PR testing, but most of the decision
16 making, I guess, would be with our oncologists
17 and our VP and the communications people. So
18 I would be providing the VP with updates on
19 how many cases we had received and whatnot,
20 and what we were doing to review--conducting a
21 review in terms of trying to ascertain what
22 went wrong in the system.
23 COFFEY, Q.C.:
24 Q. Doctor, the idea of key messages, like that
25 phrase, key messages -

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. Is that the sort of phrase that is used in the
5 pathology world?
6 DR. COOK:
7 A. Key messages?
8 COFFEY, Q.C.:
9 Q. Yes.
10 DR. COOK:
11 A. I can't say for sure.
12 COFFEY, Q.C.:
13 Q. No, I appreciate that, but in your world, in
14 your work-a-day world, day to day -
15 DR. COOK:
16 A. Key messages?
17 COFFEY, Q.C.:
18 Q. Key messaging.
19 DR. COOK:
20 A. It wouldn't be a term I'd normally use.
21 COFFEY, Q.C.:
22 Q. And if we could, please, Registrar, Exhibit P-
23 1935? Now Doctor, this--these are your--some
24 of your handwritten notes.
25 DR. COOK:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. And the first of these is August 4th, 2005,
4 2:15 p.m. You write "spoke to Maria Mendes at
5 Mount Sinai" and what does that say then?
6 DR. COOK:
7 A. "About logistics of setting up stains of
8 paraffin blocks. She states it may take three
9 to four weeks to do four to five hundred
10 blocks."
11 COFFEY, Q.C.:
12 Q. And then there's--now on that, if we could
13 bring up, please, Exhibit P-1936? Now this is
14 a note, Maria Mendes, a phone number.
15 DR. COOK:
16 A. Um-hm.
17 COFFEY, Q.C.:
18 Q. "Gather up information, slides, stains,
19 interpretation, 500 paraffin block, three -
20 DR. COOK:
21 A. - to four week turnaround time."
22 COFFEY, Q.C.:
23 Q. Now Doctor, I take it this is your handwriting
24 too?
25 DR. COOK:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Doctor, this sort of a note, would this be
4 made while you were speaking and then
5 transcribed into the one we just looked at, or
6 would you--I'm just trying to get some sense
7 for the Commissioner, because we have--
8 sometimes we have notes, and this may have
9 been done even before you made the phone call,
10 I don't know. I'm just trying to get some
11 sense of when you would make notes, in what
12 circumstances you'd make various types of
13 notes.
14 DR. COOK:
15 A. Well, something like that, I can tell by the
16 quality of my handwriting, that would be
17 writing that down when I'm speaking to the
18 individual at the same time.
19 COFFEY, Q.C.:
20 Q. Okay, and if we could then, Exhibit P-1935,
21 please? So this sort of a note, and--so we
22 have a number of these we're going to look at.
23 They're kind of running--some of them are in
24 chronological order -
25 DR. COOK:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. - in time, date and time, and we're going to
4 see some there slightly out of order, in terms
5 of their listing. So when would you make this
6 kind of a note?
7 DR. COOK:
8 A. Well, it was made at the time, the date
9 specified.
10 COFFEY, Q.C.:
11 Q. Okay. So would you have parallel systems of
12 notes or just make the one at -
13 DR. COOK:
14 A. Well, it depends. I mean, if I didn't have my
15 binders with me, and sometimes I didn't have
16 my binders in my office, I would write on
17 scraps of paper and then if I remember,
18 transcribe those notes to the binders.
19 COFFEY, Q.C.:
20 Q. And if at the time, for example, it was later
21 in the afternoon and you realized--you knew
22 that it was 2:15 that day that you had called
23 Maria Mendes, you could do that too? You'd
24 just make a note?
25 DR. COOK:

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1 A. If I could recollect the time.
2 COFFEY, Q.C.:
3 Q. Or it might be that this was done at the
4 actual time itself.
5 DR. COOK:
6 A. It may be or I would have the actual time on
7 another slip of paper and transcribe that into
8 the binders.
9 COFFEY, Q.C.:
10 Q. With that then as background here, there's a
11 note here, August 5th, 2005, 9 to 10:30 p.m.
12 or a.m.?
13 DR. COOK:
14 A. It must be a.m.
15 COFFEY, Q.C.:
16 Q. a.m., yes. Meeting with Dr. Carter, Cook,
17 Heather Predham. "Agreed to generate a master
18 list with cross reference to the Cancer
19 Treatment and Research Foundation list to
20 ensure no patients are missed. This has to be
21 generated before blocks can be referred to
22 Mount Sinai." August 5, 2005, 12:20 p.m.,
23 "spoke to Dr. Pritzker, advised us he will
24 help us in any way. Advised us not to go
25 public. We are the first lab known to handle

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1 the situation this way." Now in terms of your
2 discussion with Dr. Pritzker and not going
3 public, do you recall what that was about?
4 DR. COOK:
5 A. Well, I would have given him background
6 information that we were conducting a massive
7 review. I would have commented about our
8 conversion rates of samples, how we identified
9 the index case going from the DAKO to the
10 Ventana system, and that we were going to
11 retest all our negatives. I think what he
12 meant in that regard, advised us not to go
13 public, was not to go public at that
14 particular time. The impression I get is not
15 to go public ever, but not to go public at
16 that particular time, until we knew the scope
17 and extent of the issue we were dealing with.
18 COFFEY, Q.C.:
19 Q. And then you go on on these notes, Doctor, to
20 say--I'll refer to August 5th, 2005, 3 p.m.,
21 "meet with pathologists to discuss the
22 situation." We've seen another note on that.
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. August 5, 2005, "Ventana company
2 representative okayed the system" and then the
3 same day at 4:15 p.m., Dr. Williams, Gardiner,
4 Laing, Heather Predham, Pat Pilgrim and
5 yourself, "start from March 31, 2004, go
6 backwards, only on live patient, database."
7 Do you recall what that was about, this last
8 entry?
9 DR. COOK:
10 A. Again, this was, I believe, priority based on
11 those tests under the DAKO system, as opposed
12 to Ventana. So we concentrated on the DAKO
13 system.
14 COFFEY, Q.C.:
15 Q. If we could, please, page six of--I apologize,
16 Exhibit P-1936? Just going to go to page six,
17 Commissioner. This reads "Dr. Anwar called
18 August 10th, 2005 11:50 a.m., advised prior to
19 '99 to send in ER negative case. If reported
20 as ER negative less than 30 percent, '99
21 beyond, Clarenville sent to Mount Sinai."
22 Doctor, what was this note about?
23 DR. COOK:
24 A. Well, I was calling all the laboratory
25 directors at that time, and I was probably

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1 calling before I sent out the memos to speak
2 to them about our situation and the fact that
3 we were conducting a review and that we wanted
4 the blocks and the slides sent in. In this
5 particular case, there was information relayed
6 to me by Dr. Anwar that sometime in 1999,
7 cases were sent to Mount Sinai for staining,
8 and what I thought interpretation at that
9 time, and referred back to Clarenville for
10 reporting in their hospital information
11 system.
12 COFFEY, Q.C.:
13 Q. And Dr. Anwar was located in Clarenville?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. In '05. Had you known about this before this?
18 DR. COOK:
19 A. Yes, I did.
20 COFFEY, Q.C.:
21 Q. About the situation in Clarenville?
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. And so here then, you were asking Dr. Anwar to

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1 send anything before they got involved with
2 Mount Sinai?
3 DR. COOK:
4 A. Yes.
5 COFFEY, Q.C.:
6 Q. To gather up the cases that were negative
7 before that time?
8 DR. COOK:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Using that cutoff, 30 percent cutoff?
12 DR. COOK:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. And send them in. Had you been aware of why
16 Clarenville, since 1999, or beginning since
17 2000 had not been sending ER/PR to St. John's?
18 DR. COOK:
19 A. Not at that time, on August the 10th. Now I
20 previously found out about that situation, it
21 was late July, early August when Heather
22 Predham told me about the situation. That was
23 at the General Hospital, next to the boardroom
24 in the office suite of the Vice President
25 Medical Services. But in terms of trying to

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1 get that information from Dr. Anwar, why
2 those--what that was discontinued, the
3 relationship was discontinued with the General
4 Hospital, he didn't have any explanation for
5 me.
6 COFFEY, Q.C.:
7 Q. And so you had spoken to Ms. Predham about it?
8 DR. COOK:
9 A. Yes.
10 COFFEY, Q.C.:
11 Q. Had you spoken to anyone else?
12 DR. COOK:
13 A. Dr. Williams.
14 COFFEY, Q.C.:
15 Q. Okay. Was it you telling Dr. Williams or him
16 telling you?
17 DR. COOK:
18 A. I believe Dr. Williams was there with myself
19 and Heather Predham when she relayed that
20 information to me.
21 COFFEY, Q.C.:
22 Q. Had you spoken to anyone else about it since?
23 Any pathologists about -
24 DR. COOK:
25 A. Yes, I spoke to a pathologist a few months

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1 after that.
2 COFFEY, Q.C.:
3 Q. Who was that?
4 DR. COOK:
5 A. Dr. Bibi Naghibi.
6 COFFEY, Q.C.:
7 Q. And when you spoke to the doctor, the doctor,
8 I take it, was in St. John's at that time?
9 DR. COOK:
10 A. She had worked in Clarenville. She came to
11 St. Clare's in 2003, so she was working at the
12 same office suite as we were.
13 COFFEY, Q.C.:
14 Q. What did she tell you then about what had
15 happened in Clarenville?
16 DR. COOK:
17 A. Well, that they weren't happy with the quality
18 of the slides and I was trying to find out
19 specifics of the quality of the slides. They
20 weren't happy with the fact that they weren't
21 getting controls with the slides. So they
22 were having--because of the quality, they were
23 having trouble with interpretation. So they
24 decided to discontinue the relationship with
25 the ER and PR slides with the General Hospital

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1 and have them stained, and I thought at the
2 time, reported from Mount Sinai.
3 COFFEY, Q.C.:
4 Q. And she had been working in Clarenville during
5 that time frame?
6 DR. COOK:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. Back in '99 through 2000?
10 DR. COOK:
11 A. I don't know exactly when she started, but
12 around that time frame, she worked there.
13 COFFEY, Q.C.:
14 Q. Okay. Exhibit--well, I'll just ask you, did
15 you make any further inquiries in that regard?
16 DR. COOK:
17 A. I did ask Dr. Anwar if he had anything or any
18 records that are available as to the reason
19 why that was discontinued from Clarenville's
20 point of view and whether there had been any
21 documentation or letters or whatever available
22 to further investigate that, and he said that
23 he would see if there was any documentation
24 around.
25 COFFEY, Q.C.:

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1 Q. And did he get back to you on that?
2 DR. COOK:
3 A. I believe he did, and--because I would have
4 talked to him on a number of occasions and the
5 response was there was no documentation.
6 COFFEY, Q.C.:
7 Q. While we're on the subject of some of your
8 notes, if we could bring up, please, Exhibit
9 P-1992? Doctor, we had just spoken about your
10 initial contact with Dr. Banerjee and we
11 looked at an e-mail and there was a
12 conversation the day before, August 2nd, 2005.
13 You'd referred to that, at 5:30. I take it
14 these are your notes on your conversation with
15 Dr. Banerjee?
16 DR. COOK:
17 A. That's correct.
18 COFFEY, Q.C.:
19 Q. And toward the bottom of the page there,
20 there's a note you've made to the effect of "a
21 bit concerned about us reporting negatives,
22 negative internal control and may suggest test
23 invalid."
24 DR. COOK:
25 A. Um-hm.

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1 COFFEY, Q.C.:
2 Q. Was that his comment or yours?
3 DR. COOK:
4 A. That was probably mine.
5 COFFEY, Q.C.:
6 Q. So you were conveying this to him?
7 DR. COOK:
8 A. Yes.
9 COFFEY, Q.C.:
10 Q. This is the conclusion you'd already reached,
11 based upon your look at the slides?
12 DR. COOK:
13 A. Previous looking at the batches of the 25s and
14 the 33s, I believe.
15 COFFEY, Q.C.:
16 Q. And there's a note here "don't admit to error
17 with the old system as it was the technology
18 of the day. Use a variety of controls," and
19 good something?
20 DR. COOK:
21 A. Good idea.
22 COFFEY, Q.C.:
23 Q. Good idea, and "collaborate with Mount Sinai."
24 DR. COOK:
25 A. Yeah.

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1 COFFEY, Q.C.:
2 Q. So this reference to "don't admit to error
3 with the old system as it was technology of
4 the day,"
5 DR. COOK:
6 A. Right.
7 COFFEY, Q.C.:
8 Q. Whose comment was that?
9 DR. COOK:
10 A. Dr. Banerjee's.
11 COFFEY, Q.C.:
12 Q. So how was it that that subject came up?
13 DR. COOK:
14 A. I can't say for sure. I mean, I said--I would
15 have given him the background to what has
16 happened, the extent of the review they were
17 going through in terms of the retesting. I
18 mean, obviously, I mean, it was going to be,
19 you know, legal matters arising out of that.
20 I can't remember talking to him specifically
21 about legal issues, but other than the fact
22 that that statement did come from him.
23 COFFEY, Q.C.:
24 Q. If we could look, please, at Exhibit P-1938?
25 Now Doctor, here, this is a letter of August

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1 10th, 2005 to yourself. It's from Nancy
2 Impala, Department of Pathology in Montreal
3 General, and she says "as discussed with Dr.
4 Watters, please find enclosed ER/PR stained
5 slides you requested on the following cases"
6 and there's a listing of surgical numbers,
7 some with percentages of ER/PR, and the next
8 page of this exhibit is handwritten, in effect
9 a handwritten spreadsheet. Some of it's
10 redacted. It says received July 29th, 2005.
11 DR. COOK:
12 A. That's correct.
13 COFFEY, Q.C.:
14 Q. 2002 cases. Is this in your handwriting?
15 DR. COOK:
16 A. That's my handwriting.
17 COFFEY, Q.C.:
18 Q. And what are you attempting to do here,
19 Doctor?
20 DR. COOK:
21 A. We're doing a correlation there with our
22 results from the DAKO, the Ventana and looks
23 like Mount Sinai results coming back. So
24 we're seeing the results of the ER and PR
25 using the different platforms.

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1 COFFEY, Q.C.:
2 Q. Reference here, it says "received July 29th,
3 2005, and presented to August 1st, 2005
4 meeting with steering group." See that?
5 DR. COOK:
6 A. That must have been that meeting of August 1st
7 at five p.m.
8 COFFEY, Q.C.:
9 Q. With Mr. Tilley et al?
10 DR. COOK:
11 A. Yes, all those individuals.
12 COFFEY, Q.C.:
13 Q. So this, the information that you gleaned from
14 this comparison, you would have conveyed to
15 the people at the meeting?
16 DR. COOK:
17 A. I would have.
18 COFFEY, Q.C.:
19 Q. Overall, what impression did you have?
20 DR. COOK:
21 A. You're looking at the sensitivity of the
22 Ventana system. You're getting much higher
23 signals and percentages than the DAKO system
24 from Mount Sinai.
25 COFFEY, Q.C.:

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1 Q. Here, on page three of the exhibit, there's
2 some other handwriting. Cases from Montreal
3 received August 11th, 2005.
4 DR. COOK:
5 A. Um-hm.
6 COFFEY, Q.C.:
7 Q. It reads "cases read by Dr. Carter blind, no
8 standardization of Ventana system. Montreal
9 positive controls okay. Internal control,"
10 and you can read that. It's right there.
11 DR. COOK:
12 A. Tissue are negative.
13 COFFEY, Q.C.:
14 Q. Oh, I apologize, tissue are negative.
15 Montreal slides, same quality as DAKO slides,
16 M for moderate, S for strong, F for faint. Is
17 this your handwriting?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And what are you doing here, Doctor? What's
22 this?
23 DR. COOK:
24 A. Well, the original intent of using Montreal,
25 Montreal has a Ventana system similar to ours

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1 in place. So we wanted to send the cases up
2 to Montreal to do a comparison between their
3 Ventana system and ours. What had happened,
4 when those blocks got there, Montreal utilizes
5 two systems, automated and semi-automated
6 systems. The automated system was at capacity
7 at that time, in the middle of the summer, so
8 someone decided to retest our specimens on
9 their semi-automated system. So there was a
10 miscommunication there and our slides got
11 retested on their semi-automated system.
12 COFFEY, Q.C.:
13 Q. I take it because you'd wanted the slides you
14 had sent up to Montreal to be tested on their
15 automated system?
16 DR. COOK:
17 A. Automated system and do a correlation between
18 our system and theirs.
19 COFFEY, Q.C.:
20 Q. Now here, you have made some notes at the
21 bottom here. "Find out from Barry what
22 antibodies are inside all three." Is that--or
23 used, I'm sorry, are used in all three.
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. Used in all three. What difference would that
3 make, Doctor?
4 DR. COOK:
5 A. It may be talking about sensitivities. I
6 don't know for sure.
7 COFFEY, Q.C.:
8 Q. And you've noted here, "notice a lot of
9 staining on Montreal slides on the edge."
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. What was the significance, if any, of that?
14 DR. COOK:
15 A. Well, that would have indicated issues
16 regarding fixation.
17 COFFEY, Q.C.:
18 Q. I'm sorry?
19 DR. COOK:
20 A. Issues regarding fixation.
21 COFFEY, Q.C.:
22 Q. And all these, the tissue for all these slides
23 had come from St. John's?
24 DR. COOK:
25 A. That's right.

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1 COFFEY, Q.C.:
2 Q. And I take it when you say issues with
3 fixation, I take it that's problems with
4 fixation?
5 DR. COOK:
6 A. Problems with fixation.
7 COFFEY, Q.C.:
8 Q. "Informed Mr. Terry Gulliver, Dr. Bob
9 Williams, Dr. Kara Laing meeting of August
10 12th, 2005, done on Ventana Nexus, semi-
11 automated system, is automated system at
12 capacity."
13 DR. COOK:
14 A. Yeah.
15 COFFEY, Q.C.:
16 Q. And then you've written, "Gulliver will
17 contact Ventana regarding this."
18 DR. COOK:
19 A. I can't remember what that's about.
20 COFFEY, Q.C.:
21 Q. Okay. So you, yourself, as indicated by these
22 two handwritten spreadsheets, were doing some
23 analysis of your own?
24 DR. COOK:
25 A. That's right.

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1 COFFEY, Q.C.:
2 Q. If we could, please, Exhibit P-0569, I
3 apologize, 0569? Is this your handwritten
4 note, Doctor?
5 DR. COOK:
6 A. That's correct.
7 COFFEY, Q.C.:
8 Q. It's August 12th, 2005, "Master list finally
9 completed. Terry and Barry will spend weekend
10 recovering slides and blocks for Mount Sinai."
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. And then "Week of August 14th, 2005 Dr. Cook
15 and Dr. Fontaine will identify blocks with
16 tumour for referral to Mount Sinai."
17 DR. COOK:
18 A. Correct.
19 COFFEY, Q.C.:
20 Q. So this is, I take it, a status report to
21 yourself, as it were, a record for yourself, a
22 plan?
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. If we could bring up, please, Exhibit P-0571?
2 Now, this is two things, Doctor, it's an e-
3 mail of August 11th, 2005 from yourself to Dr.
4 Pritzker re ER and PR consultations. I take
5 it you're confirming here his suggestion as to
6 how this, the work by Mount Sinai would be
7 billed for?
8 DR. COOK:
9 A. Um-hm.
10 COFFEY, Q.C.:
11 Q. And you continue "I'm hoping to send our
12 reviews for the years 2002 and"--I'm sorry,
13 "2003 and 2002 as soon as we can compile these
14 cases, hopefully by the end of next week. We
15 will submit the others years following these.
16 I will contact Maria when we are ready to send
17 these cases to your lab. Once again, thanks
18 for your help." And then there's some
19 handwriting here. Is this your handwriting?
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. It's entitled, "Meeting with minister, August
24 15th, 2005."
25 DR. COOK:

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1 A. Right.
2 COFFEY, Q.C.:
3 Q. And August 15, 2005, 10 a.m., minister, Dr.
4 Laing, Dr. Cook, Dr. Fleming, George Tilley
5 and -
6 DR. COOK:
7 A. Moira Hennessey.
8 COFFEY, Q.C.:
9 Q. Moira Hennessey. And I think probably your
10 ADM, probably, it's cut off.
11 DR. COOK:
12 A. Yeah.
13 COFFEY, Q.C.:
14 Q. And Carolyn, communications director?
15 DR. COOK:
16 A. Um-hm.
17 COFFEY, Q.C.:
18 Q. Doctor, could you just take us through what
19 you've written here?
20 DR. COOK:
21 A. Well, you want me to read down through?
22 COFFEY, Q.C.:
23 Q. Yes, if you could, please, because some of
24 it's -
25 DR. COOK:

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1 A. "Public obligation for disclosure. Need about
2 two months for complete information. Will
3 hold off letter until all information is
4 received."
5 COFFEY, Q.C.:
6 Q. And what was that about, Doctor?
7 DR. COOK:
8 A. Well, I guess, if I remember correctly, this
9 was a meeting that we had with the minister at
10 the conference room in the Department of
11 Health, Confederation Building. And that
12 meeting was, from what I saw, to provide him
13 with an update of what we were doing with the
14 ER and PR at that particular time, and
15 basically the issue of public disclosure came
16 up. I think this was the overriding theme
17 that came up in that particular meeting.
18 COFFEY, Q.C.:
19 Q. And what do you recall about that?
20 DR. COOK:
21 A. The minister was concerned that Eastern Health
22 hadn't gone public at that particular time and
23 that he was pressing for public disclosure.
24 COFFEY, Q.C.:
25 Q. What, if anything, was he told, do you recall?

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1 DR. COOK:
2 A. There was a concern from our oncologists, I
3 believe Dr. Laing, that if we went--if we
4 disclosed at this particular time before we
5 had all the results back, that this would
6 create a lot of undue fear and anxiety amongst
7 the population.
8 COFFEY, Q.C.:
9 Q. And do you recall anything else about what was
10 said about that?
11 DR. COOK:
12 A. I think the minister was still favouring
13 public disclosure at that time. Dr. Laing was
14 quite firm in holding off on that until we've
15 got, until we go the results back from Mount
16 Sinai.
17 COFFEY, Q.C.:
18 Q. Did you contribute anything to that
19 conversation?
20 DR. COOK:
21 A. Well, I would have probably said we were
22 looking at a time frame of getting the results
23 back sometime in September and hopefully we
24 would have had the results then compiled and
25 then a plan of action in regards to treatment

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1 regimes given to the patients, or to the
2 attending physicians.
3 COFFEY, Q.C.:
4 Q. So the reference here to "Need about two
5 months for complete information" looking at
6 those present, I take it you would have been
7 the most knowledgable in the room?
8 DR. COOK:
9 A. In regards to that, yes.
10 COFFEY, Q.C.:
11 Q. Yes. Doctor, if we just continue on on the
12 same page, is there anything else, do you
13 recall, about the meeting of relevance here?
14 DR. COOK:
15 A. No, other than the fact about the public
16 disclosure was the primary thing.
17 COFFEY, Q.C.:
18 Q. How about telling the patients?
19 DR. COOK:
20 A. That was, until we got the results back, the
21 feeling was to hold off on telling the--as
22 soon as the results came in they would be
23 informed on an individual basis, as soon as
24 the results came in.
25 COFFEY, Q.C.:

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1 Q. But in the meantime they wouldn't be
2 individually advised about the fact that their
3 tissue samples were being retested?
4 DR. COOK:
5 A. No.
6 COFFEY, Q.C.:
7 Q. And was that discussed at that meeting, the
8 idea of telling the individual patients that,
9 look, we are retesting your tissue sample?
10 DR. COOK:
11 A. I can't recollect that being discussed.
12 COFFEY, Q.C.:
13 Q. Okay.
14 COMMISSIONER:
15 Q. And when you say they would be told, would
16 that be the ones that would be a change or all
17 of them?
18 DR. COOK:
19 A. Commissioner, I believe that would have been
20 initially those that had a result, a
21 conversion.
22 COMMISSIONER:
23 Q. Um-hm.
24 COFFEY, Q.C.:
25 Q. And so those who did not convert, at that

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1 point it was not planned that they would be
2 told?
3 DR. COOK:
4 A. I can't recollect for sure, Mr. Coffey.
5 COFFEY, Q.C.:
6 Q. Okay. Doctor, what was your understanding of
7 the minister's position at the end of the
8 meeting on this whole notification issue?
9 DR. COOK:
10 A. My feeling was he still, he was still
11 concerned, he wanted to go public, but he was
12 taking our advice.
13 COFFEY, Q.C.:
14 Q. Doctor, here on the same page you've written
15 "August 16th, 2005, 11:45 a.m., spoke to Maria
16 Mendes about 100 blocks being sent up Thursday
17 or Friday. She will get back to me regarding
18 when these can be processed. Results will
19 come out on spreadsheet as opposed to
20 consultation form. I asked her, Maria, to send
21 down a copy of the spreadsheet for review and
22 to run by our executive."
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. So what was this about, Doctor?
2 DR. COOK:
3 A. We were trying to determine the format to how
4 the retro cases and the prospectives or the
5 current cases would be reported. The
6 spreadsheet was designed primarily for the
7 review cases and these would come on Excel
8 spreadsheets with a, quite a number of results
9 on the spreadsheet. The consultation forms
10 were used for our current cases, newly
11 diagnosed cases and we were looking at a
12 turnaround time of about five to six days, the
13 consultations, so they would be coming out on
14 full reports. The copy was sent down, a copy
15 of the spreadsheet was sent down from Maria
16 and I believe I forwarded that to Dr. Williams
17 for evaluation.
18 COFFEY, Q.C.:
19 Q. And was it agreed upon, the format?
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. The final entry here is August 16th, 2005,
24 12:08 p.m. "Spoke to" who is that?
25 DR. COOK:

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1 A. "Pam King Jesso." She's one of our, I think,
2 communications people, I believe.
3 COFFEY, Q.C.:
4 Q. Okay. "about," is it "about issuing Sinai
5 reports from spreadsheet" -
6 DR. COOK:
7 A. Oh, yes -
8 COFFEY, Q.C.:
9 Q. "into our" -
10 DR. COOK:
11 A. "Hospital information system and issuing the
12 hard copies of the report from Eastern
13 Health."
14 COFFEY, Q.C.:
15 Q. What was this about, Doctor?
16 DR. COOK:
17 A. Well, when they came down, the results came
18 down, I would enter them into the system,
19 verify that there was good correlation between
20 the Excel spreadsheets and our results in the
21 system, in other words, make sure there's no
22 transcription errors, issue a hard copy and
23 that hard copy would be forwarded to the
24 attending physician.
25 COFFEY, Q.C.:

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1 Q. Okay. Exhibit P-1939, please? Now, Doctor,
2 this is a memo on Health Care Corporation of
3 St. John's letterhead, it's to Maria Tracy.
4 DR. COOK:
5 A. Um-hm.
6 COFFEY, Q.C.:
7 Q. Program Director, Surgical Program and to Dr.
8 Dan Fontaine, Site Chief that the General
9 Hospital, it's from yourself as clinical
10 chief, August 23rd, 2005. The subject is
11 mastectomy specimens. And it's signed here.
12 As well, on the top right-hand corner there's
13 a September, appears to be 12:05, copy. And
14 is that your handwriting?
15 DR. COOK:
16 A. No, it's not.
17 COFFEY, Q.C.:
18 Q. Okay. But in any case, this, you've written
19 here on August 23rd, "I am requesting that all
20 mastectomy specimens be placed in a large
21 container and completely immersed in 10
22 percent Formalin. The specimen should be
23 immediately forwarded to the pathology lab
24 where the breast tumour is appropriately
25 sectioned to allow for even permeation and

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1 fixation by Formalin. Cases should not be
2 left overnight or over the weekend unsectioned
3 as this may interfere with proper fixation of
4 tissue. For cases that occur after normal
5 working hours, the pathologist on call should
6 be notified. Please make every attempt to
7 ensure these cases are done early in the day
8 and submitted to the laboratory before 4 p.m.
9 Sincerely yours, Donald Cook." Now, Doctor,
10 how did you come--why is it you came on August
11 23rd, 2005 to send this memo to Maria Tracy?
12 DR. COOK:
13 A. Well, this would have been we were going
14 through the cases for review from Mount Sinai
15 and, I mean, I would have been reviewing
16 probably 150, 200 cases during a two to three
17 day interval, and this would have been a trend
18 that I picked up following review of those
19 cases in aggregate. And it was the first time
20 I really noticed that that type of trend
21 existed. I mean, there was problems with the
22 fixation of the tissue, by means of that I
23 mean varying degrees of fixation problems from
24 one tissue to the next. So the only thing I
25 could surmise of that was that this appeared

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1 to be a problem of tissue left overnight and
2 over on the weekends. So that memo was sent
3 to Maria to address that issue.
4 COFFEY, Q.C.:
5 Q. So did you get any response to the memo?
6 DR. COOK:
7 A. I got no response.
8 COFFEY, Q.C.:
9 Q. And this subject matter did come up again,
10 though, later?
11 DR. COOK:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. In September, another letter, and we'll get to
15 that.
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. Now, Doctor, just looking at that, your
20 remarks here are in respect of mastectomy
21 specimens?
22 DR. COOK:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. Were they limited to those sorts of specimens

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1 or was there--and I appreciate you were only
2 looking at ER/PR slides?
3 DR. COOK:
4 A. Um-hm.
5 COFFEY, Q.C.:
6 Q. And the related H & E slides. But, these
7 concerns about tissue being left in Formalin
8 over the weekend, overnight or over the
9 weekend, would they apply to other types of
10 specimens, as well?
11 DR. COOK:
12 A. Well, actually, they did, yes. Any time we
13 were notified by the OR, these not only
14 included breast tissue, but other specimens
15 such as bowels and lungs and whatnot.
16 COFFEY, Q.C.:
17 Q. Now, prior to this point in late August, 2005,
18 as clinical chief, do you ever recall this
19 being raised with the peri-operative program?
20 DR. COOK:
21 A. No.
22 COFFEY, Q.C.:
23 Q. Like, during the years you'd been clinical
24 chief?
25 DR. COOK:

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1 A. No.
2 COFFEY, Q.C.:
3 Q. Okay. Had it ever been raised in the years
4 before you were clinical chief, while you were
5 site chief at St. Clare's, to your knowledge?
6 DR. COOK:
7 A. No.
8 COFFEY, Q.C.:
9 Q. Doctor, you've indicated that this arose out
10 of a situation where over a short period of
11 time, two or three days, you were reviewing
12 many, many slides?
13 DR. COOK:
14 A. Yes.
15 COFFEY, Q.C.:
16 Q. Had you ever had occassion to do that before,
17 to be in a situation where you were sitting
18 and looking at, like, at a grouping of slides
19 like that drawn from a number of years, had
20 you ever done that before?
21 DR. COOK:
22 A. No. That was the first time.
23 COFFEY, Q.C.:
24 Q. I take it then the pattern that you saw, a
25 pattern was apparent to you when you looked at

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1 it then because of the concentrated time
2 frame?
3 DR. COOK:
4 A. Yes.
5 COMMISSIONER:
6 Q. Excuse me, Mr. Coffey.
7 COFFEY, Q.C.:
8 Q. Yes.
9 COMMISSIONER:
10 Q. Was there, at that time, Dr. Cook, a system
11 whereby the OR notified the lab on a regular
12 basis that specimens were available or how did
13 that work?
14 DR. COOK:
15 A. Well, there would be a portering system.
16 COMMISSIONER:
17 Q. Um-hm.
18 DR. COOK:
19 A. They would, as soon as the specimens come out,
20 there would be a batching of the specimen and
21 they would be sent up to the lab on that same
22 day. And I think there were two runs, if I
23 remember correctly, one in the morning and one
24 in the afternoon. But what we would do on a
25 routine is ourselves, we would go down and

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1 check the OR, one of the techs would go down
2 or I've gone down myself just to check the
3 frozen section room where our specimens were
4 kept just to make sure that there weren't any
5 big specimens lying around overnight,
6 Commissioner.
7 COMMISSIONER:
8 Q. And was there some program for, for example,
9 if there was an emergency on the weekend or
10 I'm assuming that your lab isn't as busy on
11 the weekends as it would be during the week
12 when, perhaps that's an incorrect assumption,
13 but I'm assuming there wouldn't be many
14 surgeries on the weekend?
15 DR. COOK:
16 A. No, that's correct. It was only -
17 COMMISSIONER:
18 Q. Except for emergencies?
19 DR. COOK:
20 A. Only emergencies.
21 COMMISSIONER:
22 Q. Okay. And was there a system then to make
23 sure things got to the lab if they were -
24 DR. COOK:
25 A. Only if there was a requirement for a frozen

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1 section or the tissue be handled in a certain
2 manner. Let's say there was a patient being
3 operated on for lymphadenopathy, say, enlarged
4 lymph nodes, surgeon went in to the abdomen
5 and found enlarged lymph nodes and needed a
6 work up on those nodes, we would go through
7 something along the lines of a lymphoma
8 protocol which we would be called in to
9 address the tissue in a certain manner. So we
10 would be called in for a situation like that
11 only if the attending surgeon deemed it
12 necessary. Now, for someone who had, say, a
13 perforated bowel or whatever, that specimen
14 wouldn't be transported to the lab on the
15 weekend, it would remain in a Formalin
16 container until Monday morning.
17 COMMISSIONER:
18 Q. Okay. And there presumably was a protocol to
19 deal with that, was there, a written protocol?
20 DR. COOK:
21 A. For the -
22 COMMISSIONER:
23 Q. For how to deal with things on the weekend,
24 what required a call to be made, what could be
25 left in Formalin -

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1 DR. COOK:
2 A. I believe there was a written protocol. I'm
3 not absolutely sure on that. But that in
4 terms of a frozen section or whatever, that
5 would have been automatic.
6 COMMISSIONER:
7 Q. Okay.
8 COFFEY, Q.C.:
9 Q. Exhibit P-0573, please? Doctor, these are
10 some handwritten notes of Dr. Williams. The
11 typed version is at page 3 of the exhibit.
12 The attendees are Mr. Gulliver and Dr.
13 Williams but you are referenced here. And
14 there's a note here, "All blocks given to Dr.
15 Cook yesterday for St. Clare's and Grace site,
16 1999 to the first three months of 2004." And
17 "Dr. Cook has contacted Mount Sinai and
18 advised that the blocks will be sent this
19 week. They will do so as soon as possible.
20 Dr. Cook says 2002, 2003 to 2004 should be
21 ready to go today." And then there's a
22 reference, "Note that Montreal's Ventana's
23 testing was done on semi-automated system and
24 compares very, very closely to our DAKO
25 results in the same seven patients. The

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1 reports provide excellent correlation of the
2 DAKO and Ventana semi-automated systems." And
3 there's a reference to Mr. Tilley and Dr.
4 Fleming advised. This conclusion about the
5 comparison between the semi-automated Ventana
6 at Montreal and the DAKO cases locally, was
7 that your conclusion, this comparison?
8 DR. COOK:
9 A. I was looking at the correlations in terms of,
10 so in terms of the correlations that was my
11 conclusion.
12 COFFEY, Q.C.:
13 Q. That's the kind of handwritten spreadsheets we
14 were looking at earlier, one of those.
15 DR. COOK:
16 A. Yes, in terms of the percentages reported.
17 COFFEY, Q.C.:
18 Q. Okay. Exhibit P-0574 please? This is a memo
19 from yourself to Maria Mendes, August 17th,
20 2005, Repeat ER/PR Receptors is the subject
21 matter. And it's noted August 18th, 2005,
22 Purolator approximately 115 blocks. August
23 19th, 2005, HSC '99, 2000, 2001, St. Clare's--
24 SCH would be St. Clare's Hospital, 2000, 2001
25 sent -

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1 DR. COOK:
2 A. That's correct.
3 COFFEY, Q.C.:
4 Q. These are your handwritten notes as to what's
5 gone.
6 DR. COOK:
7 A. Yes, right.
8 COFFEY, Q.C.:
9 Q. And here you write, "As discussed, I'm
10 requesting the performance interpretation of
11 estrogen and progesterone receptor IHC stains
12 using the LSAB procedure on the enclosed
13 blocks. Each block is submitted in a plastic
14 bag with demographic information and
15 pathological interpretation. It would be
16 appreciated that the paraffin blocks and the
17 stain, the ER/PR slides be returned to my
18 office at St. Clare's site. It would also be
19 appreciated if the spreadsheet containing the
20 ER and PR interpretation could be faxed to my
21 office upon completion. If you have any
22 questions, please call me. Donald Cook." So,
23 Doctor, was this the first then grouping or
24 batching, batch that went off to Mount Sinai?
25 DR. COOK:

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1 A. I believe so.
2 COFFEY, Q.C.:
3 Q. And what they were consisted of, I take it, is
4 set out in this description here in your
5 handwriting at the top? Like here--or not, I
6 don't know.
7 DR. COOK:
8 A. 115 blocks sent on August 18th.
9 COFFEY, Q.C.:
10 Q. August 18th. There may have been, I take it
11 this reference to August 18th, there may have
12 been more blocks sent then the next day.
13 DR. COOK:
14 A. More blocks sent.
15 COFFEY, Q.C.:
16 Q. Okay, now Doctor, how was the--how were you in
17 St. John's keeping track of what was going
18 out?
19 DR. COOK:
20 A. Oh, we had that information on the
21 spreadsheets compiled by Mr. Dyer and Mr.
22 Gulliver and anything that went out was
23 recorded by those individuals. And I guess
24 our secretaries would have been involved in
25 the recording process as well.

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1 COFFEY, Q.C.:
2 Q. Were these spreadsheets handwritten or
3 computerized?
4 DR. COOK:
5 A. They were handwritten.
6 COFFEY, Q.C.:
7 Q. And who was responsible for maintaining the
8 record of what was gone?
9 DR. COOK:
10 A. Oh, that would be one of our secretaries who
11 would log the case into our computer system,
12 data entry operators and that would be kept as
13 a record of what went out.
14 COFFEY, Q.C.:
15 Q. But in terms of, I take it, what went out in a
16 particular batch would be recorded in a
17 handwritten spreadsheet?
18 DR. COOK:
19 A. In a handwritten spreadsheet and I believe in
20 a Meditec at that time and then Mr. Dyer would
21 be notified.
22 COFFEY, Q.C.:
23 Q. When you say in Meditec, how in Meditec?
24 DR. COOK:
25 A. Well for every block that goes out -

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1 COFFEY, Q.C.:
2 Q. Yes.
3 DR. COOK:
4 A. That block is supposed to be recorded into the
5 system.
6 COFFEY, Q.C.:
7 Q. For that patient, the fact that you're sending
8 block A, for example, for a particular patient
9 with a particular surgical number.
10 DR. COOK:
11 A. That should be recorded.
12 COFFEY, Q.C.:
13 Q. In that patient's Meditec chart?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Okay, and who is responsible for doing that,
18 do you recall?
19 DR. COOK:
20 A. That was generally one of our secretaries.
21 COFFEY, Q.C.:
22 Q. Exhibit P-0576. Doctor, these are your
23 handwritten notes?
24 DR. COOK:
25 A. Uh-hm.

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1 COFFEY, Q.C.:
2 Q. Of August 18th, 2005. "Observation, cases,
3 2001, 2001, fixation is a major problem in at
4 least 15 to 20 percent of cases."
5 DR. COOK:
6 A. Uh-hm.
7 COFFEY, Q.C.:
8 Q. "A lot of high grade lesions."
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. What's the significance of a lot of high grade
13 lesions?
14 DR. COOK:
15 A. These are undifferentiated carcinomas, most of
16 these are usually negative for ER and PR and
17 they, you lose a lot of tubular configuration
18 and glandular configuration, so they tend to
19 be more aggressive lesions.
20 COFFEY, Q.C.:
21 Q. And would that have any relevance to the ER/PR
22 matter?
23 DR. COOK:
24 A. It could if you got a large population that
25 has a large number of--a significant number of

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1 your population has high grade lesions, you
2 can get a lot of negatives for ER and PR.
3 COFFEY, Q.C.:
4 Q. And the reference here to "fixation being a
5 major problem in at least 15 to 20 percent of
6 cases."
7 DR. COOK:
8 A. Uh-hm.
9 COFFEY, Q.C.:
10 Q. Problem to what extent? You just
11 characterized it as major.
12 DR. COOK:
13 A. Ah, in terms of the 15 to 20 percent, you
14 know, for that particular year, '01 and '02,
15 now there are varying degrees of fixation
16 problems on each slide. I mean, some of the
17 slides would show minor fixation problems
18 probably comprising of 5 percent of the
19 surface area; some would show fixation
20 problems, maybe of 30 to 40 percent. So the
21 degree of fixation varied from slide to slide.
22 COFFEY, Q.C.:
23 Q. Doctor, at this point in time, just past mid
24 August, 2005, did you have any understanding
25 as to what, if any, might be the ramifications

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1 of fixation problems for ER and PR in
2 particular?
3 DR. COOK:
4 A. Not particularly for ER and PR. I was looking
5 at the ramifications for interpretations. But
6 in terms of ER and PR, no.
7 COFFEY, Q.C.:
8 Q. You've got also a note here of August 19th,
9 2005, 10:45 a.m., "Spoke to Dr. Barry
10 Gallagher", I take it who is a pathologist in
11 Gander?
12 DR. COOK:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. "Advised on our hold on ER/PR reporting,
16 stated that Mount Sinai will be the issue
17 report, continue to refer ER and PR into St.
18 John's. Copy of Mount Sinai report will be
19 faxed back to you for entry into hospital
20 information system. General discussion
21 followed on immunoperoxidase technique in
22 general."
23 DR. COOK:
24 A. Uh-hm.
25 COFFEY, Q.C.:

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1 Q. And then you've also noted here that August
2 10th, 2005, 11:50 a.m., Clarenville, we've
3 seen another note to this effect, but you're
4 talking to Dr. Anwar.
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. Now in terms of Dr. Gallagher, was this your
9 first contact with him about this matter?
10 DR. COOK:
11 A. I can't say for sure, Mr. Coffey.
12 COFFEY, Q.C.:
13 Q. It was in during this time period, I take it,
14 you were contacting individual pathologists
15 across the province to talk to them about
16 this?
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And we'll see a number of other notes to that
21 effect.
22 DR. COOK:
23 A. Uh-hm.
24 COFFEY, Q.C.:
25 Q. Did you indicate to Dr. Gallagher, do you

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1 recall in August of 2005, what you had gleaned
2 up to that point?
3 DR. COOK:
4 A. That we had a problem with our system, it
5 looked like we were having issues at the
6 technical aspect of it, we were getting
7 conversions, I was thinking more problem
8 within the lab at a specific point in the
9 process. I may have talked to him about
10 interpretations and that was generally the
11 theme in most of my discussions with the
12 laboratory directors, how the cases were
13 interpreted.
14 COFFEY, Q.C.:
15 Q. And you've told them that perhaps or did you
16 tell him that from your perspective there had
17 been interpretation problems in St. John's?
18 DR. COOK:
19 A. I may have. Again, I can't recollect that,
20 but from their perspective, they were looking
21 at how it affected the individual pathologists
22 in his or her own situation.
23 COFFEY, Q.C.:
24 Q. And what about the fixation problem you
25 noticed in St. John's, did you raise that do

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1 you recall with Dr. -
2 DR. COOK:
3 A. I can't remember raising that because at that
4 time I was just looking at a few cases. I
5 can't remember raising the fixation problem.
6 COFFEY, Q.C.:
7 Q. And that would be with St. John's, anyway
8 cases, they wouldn't be Gander's cases.
9 DR. COOK:
10 A. It wouldn't be Gander.
11 COFFEY, Q.C.:
12 Q. We've seen reference in passing to Dr.
13 Fleming?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. What was Dr. Fleming's involvement in this,
18 from your perspective?
19 DR. COOK:
20 A. I think he worked with MCP and he worked with
21 Cathi Bradbury, so it may have been a time
22 that she was on vacation or out of town that
23 Dr. Fleming would be filling in for her.
24 COFFEY, Q.C.:
25 Q. Okay. And looking back on it, do you recall

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1 him or Doctor Bradbury really having much
2 input into this whole matter?
3 DR. COOK:
4 A. I can't remember him having any input.
5 COFFEY, Q.C.:
6 Q. How about Dr. Bradbury, until the very end, in
7 May of '07?
8 DR. COOK:
9 A. I don't think she was there at any of the
10 meetings that I had with the ministers.
11 COFFEY, Q.C.:
12 Q. Exhibit P-0579 please? Whose handwriting is
13 this, Doctor?
14 DR. COOK:
15 A. That's my handwriting.
16 COFFEY, Q.C.:
17 Q. And there's a Tom Costello, I take it?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Who is that?
22 DR. COOK:
23 A. President of the Newfoundland and Labrador
24 Medical Association at that time.
25 COFFEY, Q.C.:

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1 Q. And what's this, this is a reference to Lab
2 City?
3 DR. COOK:
4 A. That's where he practised out of.
5 COFFEY, Q.C.:
6 Q. And so in this, you've noted here, "Spoke to
7 Tom, August 23rd, 2005, 4:28 p.m."
8 DR. COOK:
9 A. Uh-hm.
10 COFFEY, Q.C.:
11 Q. And you made a note that in fact earlier in
12 the day, 4:05 p.m., you tried to reach him at
13 a particular number.
14 DR. COOK:
15 A. Right.
16 COFFEY, Q.C.:
17 Q. And what was your purpose in contacting Dr.
18 Costello at that point?
19 DR. COOK:
20 A. To update him on the situation with ER and PR.
21 COFFEY, Q.C.:
22 Q. Had you spoken to him before about this?
23 DR. COOK:
24 A. No, this is the first time.
25 COFFEY, Q.C.:

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1 Q. And why would you be contacting him then?
2 DR. COOK:
3 A. He was the president of the Medical
4 Association and representing our physicians,
5 so it would seem, you know, prudent to call
6 him and update him on that situation. There
7 may have been a call from Dr. Williams to
8 myself asking him--asking me to update Dr.
9 Costello on the issue surrounding ER and PR.
10 COFFEY, Q.C.:
11 Q. And here, you gave background on the problem,
12 spoke about the index case, stated we are
13 retesting cases from 1997 up to August 2005.
14 Explained briefly what immunoperoxidase
15 testing was and the critical step of boiling
16 slides for antigen retrieval, different pH and
17 antibodies and dilution and titration."
18 DR. COOK:
19 A. Uh-hm.
20 COFFEY, Q.C.:
21 Q. "Spoke to him about the human element and
22 variability in the DAKO system and the
23 standardization and reproducibility of the
24 Ventana system. Talked about the sensitivity
25 of the Ventana and high conversion rates.

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1 Talked about the role of ER and PR and how
2 other types of information, ie. grade of
3 tumour, lymph node involvement affected
4 treatment, say we are using Mount Sinai as a
5 reference. Lab talked about failure to
6 identify trends and the need for
7 subspecialization and core pathology group to
8 ER/PR et cetera. Talked about a lack of
9 standardization across North America. Spoke
10 to him about having medical and technological
11 consultant coming in and review our operation.
12 Still don't have a good idea of the scope of
13 the problem until we get results back from
14 Mount Sinai, maybe another two to four weeks.
15 We have resisted going public at this time
16 until we get more information and decide how
17 we are going to tell patient, set up
18 appointment times, etcetera. We may find that
19 we may not be as or have as bad a--or not have
20 had a serious impact than initially thought.
21 Gave Tom my number and agreed to keep in touch
22 and communicate." And you've got a note here
23 to the left-hand side "do not want to create"-
24 -something--"anxiety and stress. Tom agreed."
25 So I take it he agreed with that view.

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. And then your notes go on to other phone
5 calls, I take it, or other communications?
6 DR. COOK:
7 A. Yes.
8 COFFEY, Q.C.:
9 Q. So, Doctor, at the time you spoke with Dr.
10 Costello, did he seem to already be at least
11 vaguely aware of this or was this the first,
12 from your perspective, he was hearing of it?
13 DR. COOK:
14 A. I think it's the first time he heard it.
15 COFFEY, Q.C.:
16 Q. I take it you gave him, in effect, based upon
17 your notes, a full briefing?
18 DR. COOK:
19 A. Yes, quite a lengthy briefing.
20 THE COMMISSIONER:
21 Q. Mr. Coffey, we're in time for a break.
22 COFFEY, Q.C.:
23 Q. Yes. And the idea of keeping in touch with
24 him about this, did that actually happen
25 afterward?

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1 DR. COOK:
2 A. Yes, I did, I kept in touch.
3 COFFEY, Q.C.:
4 Q. And how did that go as time went on?
5 DR. COOK:
6 A. That may have been another phone call or two
7 as time went on, just to update him on the
8 situation.
9 COFFEY, Q.C.:
10 Q. Doctor, technologists, do you know if any
11 technologists, organizing group or union or
12 whatever, was being notified about this?
13 DR. COOK:
14 A. No.
15 COFFEY, Q.C.:
16 Q. From your perspective, whose responsibility
17 would it have been, if anyone's, to notify any
18 representative of the technologists?
19 DR. COOK:
20 A. You mean as in an organization?
21 COFFEY, Q.C.:
22 Q. In the same way that you're giving a heads up
23 to your NLMA.
24 DR. COOK:
25 A. I suppose, Mr. Gulliver or, he probably would

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1 be my counterpart in the technical aspect of
2 it.
3 COFFEY, Q.C.:
4 Q. If we could then, Commissioner, I'll take it
5 up after lunch, thank you.
6 THE COMMISSIONER:
7 Q. All right then, we'll meet at 2:10.
8 (RECESS)
9 COMMISSIONER:
10 Q. Mr. Coffey.
11 COFFEY, Q.C.:
12 Q. Thank you, Commissioner. Exhibit, Registrar,
13 P-0579, please? Doctor, page 2 of this are
14 some more handwritten notes, I gather, of
15 yourself, to the effect you spoke to Terry
16 Gulliver October 23rd, 2005, 10:15 a.m. on the
17 number of cases referred in from outside St.
18 John's. And here you've noted Gander from 97
19 to 2004, less than ten percent, master log, 64
20 cases. Carbonear, 14 cases, and you've got
21 particular years, '98 to '03 and '99 to--I'm
22 sorry, '98, three, '99, four and so on,
23 Carbonear, 14 cases listed there. Then you've
24 made a notice to the master log would be sent
25 out on these cases, hopefully cases will be

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1 sent out on August 24th, 2005. There's a note
2 here, "Call Grand Falls, Corner Brook, St.
3 Anthony." I take it that you mention here,
4 "Send paraffin blocks pathology" -
5 DR. COOK:
6 A. "Pathology report" should be.
7 COFFEY, Q.C.:
8 Q. "Reports" should be. And ER and PR, I take it
9 that's what you were going to call these three
10 centres about?
11 DR. COOK:
12 A. That's correct.
13 COFFEY, Q.C.:
14 Q. And you've got a note here, "Concentrated on
15 the 1999 to March, 2004 years." I take it you
16 intended to tell them that?
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. And then there's a note here, "Spoke to Paul
21 Neil.," he's the pathologist in Corner Brook?
22 DR. COOK:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. August 23rd, 2005, 10:30 a.m., you've made a

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1 note, "Concentrated on the '99 to 2004 years.
2 Current cases refer directly to Mount Sinai.
3 Send" there's something, a name, I take it, of
4 contact individual at Mount Sinai?
5 DR. COOK:
6 A. I think that's it.
7 COFFEY, Q.C.:
8 Q. You sent it. So here this was your contact
9 with Paul Neil to tell him, I take it, the
10 status of matters and to request that he,
11 Corner Brook, send material to St. John's?
12 DR. COOK:
13 A. That's correct.
14 COFFEY, Q.C.:
15 Q. And this, I take it, Doctor, at this point you
16 expected or anticipated sending written notice
17 to that effect to him but this was a heads up
18 verbally?
19 DR. COOK:
20 A. That's correct.
21 COMMISSIONER:
22 Q. Was Corner Brook going directly to Mount Sinai
23 or to St. John's and to -
24 DR. COOK:
25 A. They were sending their retro cases to St.

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1 John's, but the newly diagnosed cases were
2 going straight to Mount Sinai.
3 COMMISSIONER:
4 Q. Okay.
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. It says, "Current cases referred directly to
9 Mount Sinai."?
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. So their current cases, they were not sending
14 them to St. John's to be sent on, they were
15 sending it direct?
16 DR. COOK:
17 A. No. At that time we were starting to feel the
18 pressure of the work coming in and our ability
19 to handle this, so I asked the directors if
20 they could forward their newly diagnosed cases
21 to Mount Sinai.
22 COFFEY, Q.C.:
23 Q. And, Commissioner, you'll recall we saw with
24 Dr. Mullen, I think, some letters in late
25 August, early September about how that was to

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1 be done?
2 COMMISSIONER:
3 Q. Um-hm. Forgive me, Dr. Cook, but I confess, I
4 had a little difficulty figuring what current
5 cases was.
6 DR. COOK:
7 A. Well, Commissioner -
8 COMMISSIONER:
9 Q. No, reading your writing.
10 DR. COOK:
11 A. Oh. The current cases are the newly diagnosed
12 cases. Those would come back in a full report
13 or another name for them, Commissioner, was
14 consultations.
15 COMMISSIONER:
16 Q. Yeah.
17 COFFEY, Q.C.:
18 Q. Now, you've got a note here, "Spoke to Maria
19 Mendes, August 23rd, 2005, 10:55 a.m. May not
20 get result until two weeks down the road as
21 blocks may have to be," what does that say?
22 DR. COOK:
23 A. "Reprocessed."
24 COFFEY, Q.C.:
25 Q. "Reprocessed. Technical issue with the

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1 blocks. Has received about 200 blocks."
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. What was this about, Doctor?
6 DR. COOK:
7 A. Well, that was the first time I've heard of
8 anything with the blocks and I spoke to Maria
9 regarding that and I said, "What's the problem
10 with the blocks?" And she was really hesitant
11 to tell me what was going on with the blocks.
12 And I said, I must have asked her a couple of
13 times, and "Is it because of there's too much
14 tissue in the blocks or the block got to be
15 melted down and re-embedded?" So I couldn't
16 get an issue (sic.) out of Maria what was
17 happening with the blocks. But -
18 COFFEY, Q.C.:
19 Q. So who had brought to your attention that
20 there was a potential technical issue with the
21 blocks?
22 DR. COOK:
23 A. Maria. So I said, "Is it anything of a
24 serious nature?" And she said, "No. It's
25 just some routine reprocessing." So I took it

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1 from that that they were going just to maybe
2 re-embed some of the tissue and maybe trim
3 down the blocks because I knew that in a
4 number of cases there was a lot of fat
5 associated with the tissue and very little
6 supporting matrix in regards to the paraffin
7 surrounding the tissue. So I took that to
8 mean that the blocks were being remelted and
9 that the tissue was being trimmed and the
10 reprocessed.
11 COFFEY, Q.C.:
12 Q. And that was happening where, you understood?
13 DR. COOK:
14 A. At Mount Sinai.
15 COFFEY, Q.C.:
16 Q. And were you ever told that that was actually
17 going on?
18 DR. COOK:
19 A. Was I ever told?
20 COFFEY, Q.C.:
21 Q. Yes, that that was actually done?
22 DR. COOK:
23 A. No.
24 COFFEY, Q.C.:
25 Q. Okay. Did you ever make any further inquiries

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1 in that regard?
2 DR. COOK:
3 A. No, I didn't.
4 COFFEY, Q.C.:
5 Q. And you've got a note here, "Tried to reach
6 Maurice Dalton on August 23rd, 2005, 12:10,"
7 and it says a.m. but I take it that's probably
8 p.m.. "Currently on holidays. Will speak to
9 him when he gets back on Monday, August 29th."
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. And he's the pathologist in Grand Falls.
14 "Spoke to Ken Green, August 23rd, 2005 12:15."
15 I take it these would be, they say a.m. but
16 this would be just past noon?
17 DR. COOK:
18 A. That's correct.
19 COFFEY, Q.C.:
20 Q. Okay. "Send all control and HER2/neu to be
21 read by Bev Carter at St. Clare's."
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. What is that about, Doctor?

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1 DR. COOK:
2 A. Well, I guess we're getting into the area of
3 sub-specialization, wanting Bev to become a
4 contact person for all the controls and
5 HER2/neus before they're sent out.
6 COFFEY, Q.C.:
7 Q. There's a note here, "Pat Pilgrim, August
8 23rd, 2005, 12:45." What's the, something
9 about Herceptin?
10 DR. COOK:
11 A. "Talked about Herceptin and the impact on the
12 lab of the new HER2/neu testing."
13 COFFEY, Q.C.:
14 Q. What was that about?
15 DR. COOK:
16 A. Prior to this when we ordered HER2/neu, this
17 would be only on the request of the
18 oncologist, but now with the new protocols
19 coming in, HER2/neu was to be ordered up front
20 on every new diagnosed breast cancer case. So
21 we needed--that would have been, require extra
22 funding for the lab to deal with that.
23 COFFEY, Q.C.:
24 Q. And you've made a note here, "Spoke to Dan
25 Fontaine August 23rd, 2005 4:05 about point

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1 person."
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. What was that about?
6 DR. COOK:
7 A. Again, that must be, again, relating to the
8 HER2/neu to be read by Dr. Carter.
9 COFFEY, Q.C.:
10 Q. Was HER2/neu then being done in St. John's?
11 DR. COOK:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And it was still being done in St. John's?
15 DR. COOK:
16 A. Well, we discontinued that in late September,
17 early August, I believe, not because of a
18 technical -
19 COFFEY, Q.C.:
20 Q. That would be late July? You said September.
21 DR. COOK:
22 A. Late August, early--late July, early August,
23 sorry.
24 COFFEY, Q.C.:
25 Q. Sorry, Doctor, go ahead.

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1 DR. COOK:
2 A. Not because of a technical issue, but because
3 we simply ran out of the HER2/neu kits. And
4 these kits are quite expensive and time
5 consuming and it was also at a time when there
6 were heavy pressures on our lab in terms of
7 workload and whatnot, so I decided if we were
8 having the ERs and PRs being tested up in
9 Mount Sinai, we could get the HER2/neus tested
10 on the same block, probably at a cheaper price
11 and at greater turn around times, so I elected
12 to go that way. Now, at the same time Dr.
13 Carter expressed an interest in upgrading our
14 HER2/neu. As I said, it was done on a kit
15 that was FDA and Health Canada approved. So
16 she was looking at transferring that possibly
17 to the Ventana system with an addition of a
18 second antibody.
19 COFFEY, Q.C.:
20 Q. And that was the status at the time. I take
21 it the HER2/neu continued to be done, then, on
22 current cases at Mount Sinai?
23 DR. COOK:
24 A. At Mount Sinai.
25 COFFEY, Q.C.:

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1 Q. Did that ever change or has that changed even
2 to this day?
3 DR. COOK:
4 A. No, that's still being done today.
5 COFFEY, Q.C.:
6 Q. If we could, please, Exhibit P-0581? Doctor,
7 I take it these are, again, a copy of some
8 notes of yours. They read, "Spoke to Barry
9 Gallagher August 24th, 2005, 10:30 a.m.
10 Advised him to send current ER and PR cases
11 directly to Mount Sinai or to Sunnybrook,
12 whichever he preferred as opposed to sending
13 them in to St. John's."
14 DR. COOK:
15 A. That's correct.
16 COFFEY, Q.C.:
17 Q. And then you note, "Spoke to Gary Baker,
18 August 24th, 2005, 11:05 a.m." Gary Baker
19 would be the pathologist in Carbonear?
20 DR. COOK:
21 A. That's correct.
22 COFFEY, Q.C.:
23 Q. Again, you've made a note, "Advised him to
24 send current ER and PRs directly to Mount
25 Sinai as opposed to sending cases to St.

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1 John's. Send copy of contact individual--sent
2 copy of contact individual at Mount Sinai." I
3 take it you gave him the name of the
4 individual he should contact?
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. And "Tried to reach Dr. Dankwa August 24,
9 2005, 11:10 a.m." That's Dr. Dankwa would be
10 the pathologist, I take it, in St. Anthony?
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. And finally, "Spoke to Maurice Dalton
15 September 1, 2005, 3:45 p.m. at great length
16 with background information. Wanted him to
17 know this before I sent out memos."
18 DR. COOK:
19 A. Right.
20 COFFEY, Q.C.:
21 Q. What was that about, Doctor?
22 DR. COOK:
23 A. Again, a lot of information there exchanged
24 between myself and Maurice, I would say we
25 probably had a half hour conversation, at

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1 least, describing the index case, how this
2 whole process was evolving, issues surrounding
3 the tests and I guess I would have been
4 talking about the, meaning technical aspects
5 of it, issues with the interpretation and the
6 review process.
7 COFFEY, Q.C.:
8 Q. And was this a more detailed or in-depth
9 conversation than you had with the other
10 pathologists out around?
11 DR. COOK:
12 A. I would say. The whole idea of me speaking
13 personally to the pathologists was for me
14 giving me an opportunity to give them the
15 heads up, also, you know, being available for
16 them to ask any questions.
17 COFFEY, Q.C.:
18 Q. And, well, you've made a particular note about
19 Dr. Dalton. Do you recall if the conversation
20 with him was perhaps longer?
21 DR. COOK:
22 A. Yes.
23 COFFEY, Q.C.:
24 Q. And if we could, please, Exhibit P-0582?
25 Doctor, these are Dr. Williams' notes of a

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1 meeting of that day, I gather. Page 2 of the
2 exhibit is the handwritten version of them,
3 I'm sorry, the typed version, actually, for
4 August 24th and 26th. And, Doctor, in the
5 first bullet for August 24th it reads, "In
6 addition to Dr. Cook's memo of August 24th,
7 2005 we will adjust our Ventana system based
8 on our new controls. When this is done, we
9 will retest on the adjusted Ventana system.
10 Same time we will send all samples to Mount
11 Sinai for retesting. We will then have one
12 year of testing on our adjusted Ventana system
13 to compare the results from Mount Sinai for
14 2004, 2005." What was that about, Doctor?
15 DR. COOK:
16 A. That I would imagine is a revalidation of the
17 Ventana system.
18 COFFEY, Q.C.:
19 Q. In relation to what?
20 DR. COOK:
21 A. In relation to the ER/PR issue and I guess in
22 relation to various observations that Dr.
23 Carter has brought up concerning the original
24 validation of the system.
25 COFFEY, Q.C.:

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1 Q. Of the Ventana system?
2 DR. COOK:
3 A. Of the Ventana system.
4 COFFEY, Q.C.:
5 Q. Did she express--did she see any shortcomings
6 in what had happened?
7 DR. COOK:
8 A. Well, she just questioned the validation
9 process.
10 COFFEY, Q.C.:
11 Q. What, if any, validation process had there
12 been for the Ventana system?
13 DR. COOK:
14 A. Well, my understanding was that Mr. Gulliver
15 and Mr. Dyer were involved in the validation
16 process and Mr. Gulliver commented that
17 hundreds of controls were used to validate the
18 Ventana system. We thought initially he was
19 talking about hundreds of ERs and PRs, but
20 what he was talking about were hundreds of
21 other known paraffin blocks and other
22 immunoperoxidase stains, so the exact number
23 of blocks related to ER and PR used to
24 validate the system was unknown, or unknown to
25 me, anyway.

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1 COFFEY, Q.C.:
2 Q. Were there any records, do you know, written
3 records of the validation process?
4 DR. COOK:
5 A. Well, I'm not sure. Again, we had that flood
6 back in November of 2004. Whether some of
7 those records were destroyed, but I really
8 don't know about the documentation of the
9 Ventana system.
10 COFFEY, Q.C.:
11 Q. And you also note, and it's also noted here in
12 Dr. Williams' notes, "Dr. Cook will be sending
13 out a number of memos on this and other
14 issues."
15 DR. COOK:
16 A. Yes. And I think memos in regard to
17 notification that the testing has been stopped
18 and send in blocks for the review of cases and
19 whatnot.
20 COFFEY, Q.C.:
21 Q. These would be memos to the other hospitals?
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Outside St. John's?

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. And it's noted, "Blocks for 2004, '05 being
5 pulled. Hope to start in-house testing on all
6 specimens, then pack the blocks to send to
7 Mount Sinai so they will be processed as soon
8 as current workload there completed."
9 DR. COOK:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. I take it this is the idea of now dealing with
13 the 2004, '05 tests?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. And getting them done at Mount Sinai?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. There's a reference in the August 26th note
22 here that Dr. Williams had met with Mr.
23 Gulliver and Mr. Dyer and "A lot of work and
24 effort has gone into ER and PR controls for
25 Ventana system. Dr. Cook reviews to confirm

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1 results. Testing to be done as soon as
2 controls verified." What was--what type of
3 testing are we talking about here?
4 DR. COOK:
5 A. Again, the validation testing, but I can't
6 remember seeing any slides that were redone on
7 the ER and PR for the revalidation.
8 COFFEY, Q.C.:
9 Q. Exhibit P-0585, please? And this is an August
10 24, 2005 letter from yourself, Dr. Cook,
11 copied to Dr. Williams, to Dr. Carter,
12 acknowledging receipt of her letter of August
13 2nd, 2005. You note, "I respect your decision
14 not to get involved in the operational aspects
15 concerning the current ER/PR review. I do,
16 however, readily recognize your role as a
17 resource individual and greatly appreciate
18 your professional advice." And so on, you
19 elaborate a bit on it. Doctor, looking back
20 on it, after August 2nd, 2005, in trying to
21 reconstruct it, how much did Dr. Carter then
22 get involved or not, you know, as time went
23 on?
24 DR. COOK:
25 A. After August 2nd, there was very little

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1 involvement with Dr. Carter in the process. I
2 was taking the lead role along with Mr. Dyer
3 and Gulliver in setting up the review process
4 and forwarding the various material on to
5 Mount Sinai. Now, in regards to her, Dr.
6 Carter's role, she was still an individual
7 there that I was relying on for advice and at
8 times guidance, where to go with this issue.
9 COFFEY, Q.C.:
10 Q. If we could see, please, Exhibit P-0580? Sir,
11 this is a memo of August 24th, 2005. It's two
12 pages. It's from yourself.
13 DR. COOK:
14 A. Um-hm.
15 COFFEY, Q.C.:
16 Q. To all lab laboratory directors, and that
17 would be throughout Newfoundland, as well as
18 Dr. Williams. It's from yourself in your role
19 as clinical chief, August 24th '05, estrogen
20 and progesterone receptors. "I wish to advise
21 you that we are doing a review of our estrogen
22 and progesterone receptors as a precautionary
23 measure at this time. Once all data is
24 compiled, we will have a better idea of the
25 scope of this issue." You say "I expect to

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1 have more information within the next few
2 weeks and will keep you updated. Please note
3 the following points." And then, if you look,
4 there are five such points spelled out.
5 DR. COOK:
6 A. Um-hm.
7 COFFEY, Q.C.:
8 Q. And this, in effect, is a memo where you're
9 telling the directors, lab directors
10 throughout the province about the hold on
11 reporting of ER/PR. Current requests being
12 sent to Mount Sinai for ER/PR testing and
13 requesting, further to your memo of June 13th,
14 that they forward all ER negative cases on
15 primary breast lesions, independent of PR
16 status, between particular dates with certain
17 cutoffs, ten percent for one and then 30
18 percent for the other. And you have other
19 requests and so on in it. Now Doctor, this is
20 signed. Do you know if this was ever actually
21 sent?
22 DR. COOK:
23 A. That actual copy wasn't sent. I spoke to Dr.
24 Williams just to notify him that I was sending
25 it out and I think he was--he made a request

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1 to me to forward that over to him, as well as
2 a copy, I believe, to Susan Bonnell in
3 communications, for them to have a look at it
4 before it was sent out.
5 COFFEY, Q.C.:
6 Q. Exhibit P-0334, please? Now Doctor, this is
7 an e-mail of August 26th, 2005 from Susan
8 Bonnell to George Tilley, yourself and Dr.
9 Williams, and she writes "as per your request"
10 and then there's a text and it reads "I wish
11 to advise"--it begins "I wish to advise you
12 that we are doing a review of our estrogen and
13 progesterone receptors. I expect to have more
14 information within the next few weeks and will
15 keep you updated. Please note the following
16 points." There are a number of points and so
17 on, not going to read all the way through it,
18 but it concludes with "if you have any
19 questions, please feel free to contact me" at
20 a particular number. That 777-5482 number is
21 yours at the office, I take it?
22 DR. COOK:
23 A. That's correct.
24 COFFEY, Q.C.:
25 Q. And what she's drafted here is to be signed

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1 "sincerely yours, Donald Cook, Clinical
2 Chief." So this was a suggested memo by--or
3 draft of the memo by Susan Bonnell?
4 DR. COOK:
5 A. Yes, the main body of the original memo is
6 unchanged. Some minor changes in
7 configuration of the memo and format, but that
8 was a look at the memo after they had a look
9 at it and Dr. Williams.
10 COFFEY, Q.C.:
11 Q. So this draft, you drafted the original one,
12 August 24th?
13 DR. COOK:
14 A. That's correct.
15 COFFEY, Q.C.:
16 Q. You gave a copy to Dr. Williams. He asked
17 that you forward a copy to Ms. Bonnell?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And you received this e-mail back?
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Was it your understanding then that you were

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1 to use this text as the memo?
2 DR. COOK:
3 A. It was an understanding. I mean, still, you
4 know, if I wanted to change things, I could,
5 but I looked at it and it looked fine to me.
6 COFFEY, Q.C.:
7 Q. Okay. If we could, please, Exhibit P-0590?
8 And this is a memo of September 6th, 2005.
9 It's to all laboratory directors. It's the
10 same subject matter. It's from yourself and
11 it includes Dr. Williams as well as a
12 recipient. The text here reads "I wish to
13 advise you that we are doing a review of our
14 estrogen and progesterone receptors. I expect
15 to have more information within the next few
16 weeks and will keep you updated. Please note
17 the following points." And then, Doctor, if
18 we were actually to go through this line for
19 line and word for word, the then text that
20 follows is really just a reformatted version
21 of your original memo, isn't it?
22 DR. COOK:
23 A. That's the original memo of August 24th, yeah.
24 COFFEY, Q.C.:
25 Q. If we could just look back, please, at P-0580,

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1 page one, in the intro? Read the first
2 sentence, it begins as saying "I wish to
3 advise you that we are doing a review of our
4 estrogen and progesterone receptors." The
5 words "as a precautionary measure at this
6 time" they are not in the September 6th memo,
7 are they?
8 DR. COOK:
9 A. No, they're not.
10 COFFEY, Q.C.:
11 Q. And as well, the words "once all data is
12 compiled, we will have a better idea of the
13 scope of this issue."
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Are those words in the September 6th memo?
18 DR. COOK:
19 A. I don't believe they are.
20 COFFEY, Q.C.:
21 Q. Okay. Did you notice at the time you got this
22 back that the precaution--reference to
23 "precautionary measure at this time" and the
24 reference to "better idea of the scope of the
25 issue" had been omitted?

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1 DR. COOK:
2 A. I may have, Mr. Coffey. I was probably paying
3 more attention to the actual body of the
4 letter and making sure the percentages were
5 correct.
6 COFFEY, Q.C.:
7 Q. Do you know--did you ever discuss that
8 particular change, the dropping of
9 "precautionary measure at this time" and
10 "better idea of the scope of the issue," did
11 you ever discuss that with anybody?
12 DR. COOK:
13 A. Can't remember discussing anything about that.
14 COFFEY, Q.C.:
15 Q. But the omission of it from one to the other,
16 I take it wasn't your doing? It was whoever
17 redrafted it?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Now Doctor, while we have--if I could, please,
22 Registrar, Exhibit P-0590? Now this is the
23 actual memo that did go out to the various
24 medical directors, the September 6th one.
25 This is the one that went, is it, Doctor?

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Okay. Now, here, Doctor, it references
5 particular dates, particular ten--like ten
6 percent cutoff, ten percent or less, 30
7 percent or less, and the specific dates or
8 periods they cover are all very clearly
9 spelled out here, aren't they?
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Doctor, I just note, just as a matter of
14 curiosity, it's defined as ten percent or
15 less.
16 DR. COOK:
17 A. Um-hm
18 COFFEY, Q.C.:
19 Q. Or 30 percent or less.
20 DR. COOK:
21 A. Yeah.
22 COFFEY, Q.C.:
23 Q. Was any thought given to whether it's ten or
24 less or should be just less than ten or less
25 than 30? Because when you particularize ten -

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1 DR. COOK:
2 A. You're saying ten percent.
3 COFFEY, Q.C.:
4 Q. - of course, ten percent or less and I'm just
5 wondering about--ask you about that, because
6 if we look back, and I'm thinking about
7 mathematical symbols, before it was less than
8 ten percent and less than 30. Did you ever
9 actually--would that ever come up about
10 whether we use ten and less and 30 and less or
11 less than ten and less than 30?
12 DR. COOK:
13 A. No, I refer back to Khalifa's original memo, I
14 believe, where he talked about 30 percent or
15 less. So that was just a minor revision in
16 regard to that original memo and applied the
17 same for the ten percent.
18 COFFEY, Q.C.:
19 Q. Back to Khalifa's '98 memo?
20 DR. COOK:
21 A. Yeah.
22 COFFEY, Q.C.:
23 Q. 1998 memo.
24 THE COMMISSIONER:
25 Q. Dr. Cook, I understood that when you were

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1 speaking earlier that in respect of the
2 business of the ten percent or the 30 percent,
3 that was really as a result of what
4 oncologists were doing at the relevant period
5 of time?
6 DR. COOK:
7 A. That's my understanding, Commissioner, from
8 Dr. Laing.
9 THE COMMISSIONER:
10 Q. Okay, and in your conversation with Dr. Laing,
11 would she have knowledge of what oncologists
12 were doing outside of the centre in which you
13 worked?
14 DR. COOK:
15 A. I couldn't say, nor could I say she had
16 knowledge of what they were doing in '97, '98
17 or '99.
18 COFFEY, Q.C.:
19 Q. Which I take it is before her time, to your
20 knowledge, in St. John's?
21 DR. COOK:
22 A. Yes.
23 THE COMMISSIONER:
24 Q. Well, I suppose, I'm also making assumptions
25 that there are oncologists in other regions

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1 who would be making determinations regarding
2 their patient based on the readings at the
3 time.
4 DR. COOK:
5 A. I can't say, Commissioner, whether there were
6 other oncologists permanently based in other
7 regions. Most of them were based in St.
8 John's and then they would -
9 THE COMMISSIONER:
10 Q. And they would go out.
11 DR. COOK:
12 A. - they would go out to the various outreach
13 clinics.
14 THE COMMISSIONER:
15 Q. All right, thank you.
16 COFFEY, Q.C.:
17 Q. Doctor, the last bullet on the page, first
18 page, says "all ERs and PRs performed on the
19 Ventana system from April 1, 2004 to August 9,
20 2005 will be referred to Mount Sinai for
21 retesting."
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. "Then also forward these cases to Mr. Barry

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1 Dyer."
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. Do you know if--because that would suggest ERs
6 and PRs, whether negative or positive -
7 DR. COOK:
8 A. Well, that would have been both negative and
9 positive.
10 COFFEY, Q.C.:
11 Q. Yes. Do you know if the other regions or
12 health authorities did send into St. John's
13 their ER positives?
14 DR. COOK:
15 A. I believe so.
16 COFFEY, Q.C.:
17 Q. Did they end up being sent off to Mount Sinai
18 or were they taken -
19 DR. COOK:
20 A. They may have been sequestered, Mr. Coffey. I
21 can't--I don't--I can't say for sure.
22 COFFEY, Q.C.:
23 Q. - taken out of the flow and just the negative
24 ER sent?
25 DR. COOK:

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1 A. I believe, I can't be sure on that.
2 COFFEY, Q.C.:
3 Q. And then, Doctor, on the next page, you set
4 out a priority list, as it were, at the
5 beginning of the page, emphasizing, at this
6 point in time, that they concentrate on
7 particular years.
8 DR. COOK:
9 A. Um-hm.
10 COFFEY, Q.C.:
11 Q. And followed by '99 to 2004, followed by '97
12 and '98, and then finally the most recent
13 cases. The reference in the last bullet on
14 this second page, "the status of the Ventana
15 system will be determined when we review
16 correlations of ER and PR results from Mount
17 Sinai and Montreal General. As a
18 precautionary measure, we are awaiting reports
19 from medical and technical consultants before
20 we operationalize the Ventana system." That's
21 operationalize in the sense of ER/PR?
22 DR. COOK:
23 A. ER/PR.
24 COFFEY, Q.C.:
25 Q. Okay. So in the meantime -

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1 DR. COOK:
2 A. Continuing on with the other IHC testing.
3 COFFEY, Q.C.:
4 Q. Did you get any--other than getting the actual
5 blocks and pathology reports and so on, did
6 you get any feedback from the medical
7 directors after you sent this out?
8 DR. COOK:
9 A. Not to me personally.
10 COFFEY, Q.C.:
11 Q. Exhibit 0589, please? Here, Doctor, and these
12 are your notes, I take it, from various
13 conversations throughout the month of
14 September?
15 DR. COOK:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. And I think--yes. Here, on September 2nd, you
19 note "spoke to Maria Mendes. Gave her a list
20 of pathology directors from Newfoundland, as
21 she was getting a number of inquiries. Try"--
22 is it -
23 DR. COOK:
24 A. "Try to have her first reports out by
25 September 9th, but no guarantee."

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1 COFFEY, Q.C.:
2 Q. And that was from her end?
3 DR. COOK:
4 A. That's correct.
5 COFFEY, Q.C.:
6 Q. There's a reference September 7th, 2005,
7 "spoke to Dr. Dankwa from St. Anthony, updated
8 him on situation and gave background
9 information before my memo sent out," or went
10 out. That would be the September 6th memo, I
11 take it?
12 DR. COOK:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. September 7th, 2005, you noted "spoke to Nancy
16 Good at Mount Sinai. Still cutting blocks.
17 Hope to start staining tomorrow." And then
18 the same day, same afternoon, you spoke to
19 Maria Mendes, "may not get first results until
20 Tuesday or Wednesday on the week of September
21 12th, 2005. Currently doing this on an
22 overtime evening basis."
23 DR. COOK:
24 A. That's correct.
25 COFFEY, Q.C.:

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1 Q. And there's a reference out here, Doctor, to--
2 what's that? Notes
3 DR. COOK:
4 A. Retro, something regarding -
5 COFFEY, Q.C.:
6 Q. Oh, I'm sorry, "retros before August 9th,
7 2005."
8 DR. COOK:
9 A. Yeah.
10 COFFEY, Q.C.:
11 Q. "Go forward beyond August 9th 2005." Is that-
12 -I'm sorry, "good forward." I take it good,
13 is that good or go?
14 DR. COOK:
15 A. It looks like good.
16 COFFEY, Q.C.:
17 Q. Good. Doctor, the current cases that Eastern
18 Health was then sending to Mount Sinai, in
19 what format were they going? I take it
20 because all of the retros were going in
21 batches, all packaged up, how were the current
22 cases sent?
23 DR. COOK:
24 A. Well, they were going as they were requested
25 by the oncologist. Newly diagnosed cases, the

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1 paraffin block, which I believe the pathology
2 report, that would be sent up separately along
3 with a requisition to Mount Sinai.
4 COFFEY, Q.C.:
5 Q. Okay, a note here, then on September 13th
6 "possibly looking at -
7 DR. COOK:
8 A. Getting results.
9 COFFEY, Q.C.:
10 Q. - getting results by this Friday.
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. Spoke to Nancy Good on the 13th, ER/PR. You
15 had spoken to her on that day, and then
16 September 14th, 2005, "ER and PR issue brought
17 to MAC."
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. That would be brought by yourself?
22 DR. COOK:
23 A. That's correct.
24 COFFEY, Q.C.:
25 Q. And I'll be asking you some more about that.

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1 September 19th, 2005, "update ER and PR at
2 clinical chiefs meeting."
3 DR. COOK:
4 A. That's correct.
5 COFFEY, Q.C.:
6 Q. So you would have given, I take it, your
7 fellow clinical chiefs, at a meeting, status
8 report as to where it was.
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Now September 21st, 2005, "Dr. Cook, Dr.
13 Carter, interviewed Trish," that would be
14 Trish Wegrynowski, and the same day, "ER and
15 PR issue brought forward to Eastern Health
16 Board by Dr. Williams." Were you present for
17 that, Doctor?
18 DR. COOK:
19 A. At the Board?
20 COFFEY, Q.C.:
21 Q. Yes.
22 DR. COOK:
23 A. No, I was on standby. If Dr. Williams
24 requested that I attend the board meeting,
25 then I would attend the board meeting at a

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1 moment's notice.
2 COFFEY, Q.C.:
3 Q. Okay, if we could, please, Exhibit P-0591?
4 DR. COOK:
5 A. Now this is an e-mail from yourself, September
6 7th, 2005, to Maria Mendes and the subject is
7 "ER and PR List". You write, "The spreadsheet
8 looks good, there are a number of names which
9 are not on the list which I presume are still
10 in the unopened envelopes." And you're
11 advising here that "more of these retro cases
12 will come once we have received them from
13 other hospitals across the province. And we
14 will also be sending more retro cases from the
15 years '97, '98, from St. Clare's site." And
16 you conclude by saying, "You can proceed with
17 the cutting, staining and reporting of those
18 cases on the sheets that you have forwarded to
19 me."
20 DR. COOK:
21 A. That's correct.
22 COFFEY, Q.C.:
23 Q. So these sheets, the spreadsheet you had
24 gotten from here, I take it listed at least
25 the cases she had, by then, logged?

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Or accessioned, I think is the word that -
5 DR. COOK:
6 A. Yes, and the names.
7 COFFEY, Q.C.:
8 Q. Now, just as an aside, Exhibit P-1282?
9 Doctor, this is a faxed transmission from Dr.
10 Williams' office, it's to yourself, September
11 8th, 2005. The subject is "Request for
12 Surgical Pathology Examination" and Denise
13 writes to you, "Please see attached form.
14 Will send you an original when we receive it."
15 I take it, Doctor, that's the form, at least
16 the new version of the form which has on it
17 "specimen will not be processed/reported
18 without clinical data"?
19 DR. COOK:
20 A. That's correct.
21 COFFEY, Q.C.:
22 Q. And I take it this was the culmination of your
23 efforts in respect of getting forms filled
24 out?
25 DR. COOK:

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1 A. Yes.
2 COFFEY, Q.C.:
3 Q. Properly. Exhibit P-0592 please? Now,
4 Doctor, this is an e-mail from, well it's
5 actually two, one September 9th from Nancy
6 Good to yourself. She writes, "I just wanted
7 to let you know that we have started cutting
8 the blocks and staining will begin next week.
9 The machine can handle 48 samples and will be
10 run after hours. We'll keep you posted on the
11 progress, thanks. Nancy." And then September
12 12th, that's a Monday, at just past noon you
13 forwarded her e-mail on to Dr. Williams.
14 DR. COOK:
15 A. Uh-hm.
16 COFFEY, Q.C.:
17 Q. Now, Doctor, I am not going to take you
18 through all of the e-mail exchanges that occur
19 as we go through the fall, I will be referring
20 you to some of them, but not all of them, with
21 Mount Sinai. In the main, from Eastern
22 Health, who was dealing with Mount Sinai? In
23 the main, who from Eastern Health was dealing
24 with Mount Sinai?
25 DR. COOK:

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1 A. That would be myself.
2 COFFEY, Q.C.:
3 Q. Yourself. And this particular e-mail, you
4 forwarded on the one from Nancy Good to
5 yourself, to Dr. Williams. We will see some
6 and the Commissioner has already seen some, e-
7 mails from Dr. Mullen to you, and you start to
8 correspond with him.
9 DR. COOK:
10 A. Uh-hm.
11 COFFEY, Q.C.:
12 Q. And at times you forward that on to Dr.
13 Williams as well?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Dr. Mullen's e-mail to you or yours to him and
18 you send a copy to Dr. Williams. As the fall
19 of 2005 then progressed, your role was what in
20 this, compared to Dr. Williams' role?
21 DR. COOK:
22 A. Mainly as a go-between, sending out blocks,
23 making sure the reports came back. If there
24 were requests from Mount Sinai for another
25 block, I would send them up. If a report came

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1 back from Mount Sinai saying there was no
2 tumour on the block or wrong block or
3 whatever, I would go back and look at the case
4 and send up another block.
5 COFFEY, Q.C.:
6 Q. And in terms of Dr. Williams?
7 DR. COOK:
8 A. He was sent that information mainly for
9 information purposes, but at times he may be
10 required to liaison with Dr. Pritzker or his
11 counterpart at Mount Sinai, if need be.
12 COFFEY, Q.C.:
13 Q. And so your purpose then in sending e-mails to
14 Dr. Williams, copying them to him or just
15 forwarding them on, ones that primarily dealt
16 with you -
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. From Mount Sinai, was to do what? You wanted
21 to keep Dr. Williams in the loop?
22 DR. COOK:
23 A. He was most interested in keeping up to date
24 with this issue and was keenly interested in
25 how quickly we were getting the reports back

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1 and start the evaluation process.
2 COFFEY, Q.C.:
3 Q. Exhibit P-1283 please? Doctor, this is an e-
4 mail from Heather Predham, September 12th,
5 2005 to yourself and Dr. Williams. The
6 subject is "Terms of Reference" and she
7 writes, "Please see attached the Terms of
8 Reference for the peer review consultant. Let
9 me know if you need any changes, thanks.
10 Heather." And, Doctor, these are two of the
11 Terms of Reference, external quality review of
12 the immunohistochemistry service and it
13 extends into page three of the exhibit.
14 Doctor, this document--the Terms of Reference
15 was prepared at whose request, do you recall?
16 DR. COOK:
17 A. Probably Dr. Williams.
18 COFFEY, Q.C.:
19 Q. And then it was being sent to you for what
20 purpose?
21 DR. COOK:
22 A. To review it and make any recommendations or
23 changes.
24 COFFEY, Q.C.:
25 Q. And I take it, having gotten the e-mail, did

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1 you review?
2 DR. COOK:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. And did you offer any changes?
6 DR. COOK:
7 A. I don't think I did.
8 COFFEY, Q.C.:
9 Q. And the Terms of Reference to be utilized by
10 whom?
11 DR. COOK:
12 A. Dr. Banerjee and Trish Wegrynowski.
13 COFFEY, Q.C.:
14 Q. Now, Trish Wegrynowski, of course, is a
15 technologist and Dr. Banerjee is a
16 pathologist. Why were the same Terms of
17 Reference used for both, do you know?
18 DR. COOK:
19 A. Well I guess Dr. Williams' understanding that
20 this was a peer review process and they were
21 to look at the lab. Dr. Banerjee was to
22 concentrate on the medical side of it and
23 Trish Wegrynowski was to concentrate purely on
24 the technical side.
25 COFFEY, Q.C.:

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1 Q. Exhibit P-1288 please? Doctor, do you
2 recognize that handwriting?
3 DR. COOK:
4 A. That's mine.
5 COFFEY, Q.C.:
6 Q. It's dated October 4, 2004, it's on Dr.
7 Williams' stationery and it says, In Central,
8 Steve Diamond, Larry Alteen and Stephanie"--
9 somebody, "Western, Susan Gillian (phonetic)"?
10 DR. COOK:
11 A. I think that's the name.
12 COFFEY, Q.C.:
13 Q. Yes, "Heidi Simms"?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. Director of Communications I think is noted
18 here. Labrador, Michael John, Carbonear, Gary
19 Baker and Jean Howse, for the Health Board
20 Association, George Tilley.
21 DR. COOK:
22 A. Uh-hm.
23 COFFEY, Q.C.:
24 Q. What was this, Doctor?
25 DR. COOK:

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1 A. These look like medical directors, I believe.
2 COFFEY, Q.C.:
3 Q. And was this a phone call or something,
4 because this is your handwriting -
5 DR. COOK:
6 A. No, this would have been, I think a conference
7 call that took place in Dr. Williams' office
8 around that time period.
9 COFFEY, Q.C.:
10 Q. And were you present for the conference call?
11 DR. COOK:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. And what do you recall about it? What was the
15 purpose and what happened?
16 DR. COOK:
17 A. Yeah, the purpose of it, if I can recollect at
18 that time, was an update on the ER/PR issue,
19 making sure that every attempt was made to
20 identify all patients who had ER/PR testing,
21 to forward these blocks in to St. John's, to
22 ensure as much as possible that there was no
23 patient falling through the cracks. And
24 that's basically all I remember about that
25 conference all.

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1 COFFEY, Q.C.:
2 Q. It is written there 2004, I take it that's--it
3 should be 2005?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And you have no memory of such a call during
8 2004?
9 DR. COOK:
10 A. Oh no, that should be 2005.
11 COFFEY, Q.C.:
12 Q. Exhibit P-1289? Do you recognize the
13 handwriting here, Doctor?
14 DR. COOK:
15 A. That's my handwriting.
16 COFFEY, Q.C.:
17 Q. Okay, it's on Dr. Williams' stationery.
18 Number one, do up brief to the board, one
19 page, September 21.
20 DR. COOK:
21 A. Uh-hm.
22 COFFEY, Q.C.:
23 Q. Number two, Diponkar's visit and Trish under
24 QI.
25 DR. COOK:

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1 A. Uh-hm.
2 COFFEY, Q.C.:
3 Q. What the--do you recall?
4 DR. COOK:
5 A. "What the service is today".
6 COFFEY, Q.C.:
7 Q. "Service is today."
8 DR. COOK:
9 A. "Review of current procedures and practice of
10 immunoperoxidase, particularly"--can't read
11 that, "of ER and PR. What improvements we
12 need to make in the future to ensure accurate
13 reliable and reproducible information, review
14 of whole of immunohistochemical staining,
15 review of current procedures, to make
16 recommendations."
17 COFFEY, Q.C.:
18 Q. And there's a reference to "talk to"?
19 DR. COOK:
20 A. Fraser.
21 COFFEY, Q.C.:
22 Q. Do you know what that's about?
23 DR. COOK:
24 A. I can't recollect that.
25 COFFEY, Q.C.:

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1 Q. Okay, and why would you have written this?
2 DR. COOK:
3 A. These were probably reminder to me what the
4 expectation of these reviewers would be, to
5 review the whole histochemical service and to
6 make recommendations.
7 COFFEY, Q.C.:
8 Q. And "do up brief to the board, one page"?
9 DR. COOK:
10 A. Yeah, I think, I can't remember being tasked
11 that, that may have been something that Dr.
12 Williams was formulating.
13 COFFEY, Q.C.:
14 Q. Exhibit P-1288 please? The second, page two
15 of it, page two and three of this exhibit are
16 a letter of September 21st, 2005, addressed to
17 Terry Gulliver as a program director. It's
18 from Dan Fontaine, the site chief at the
19 Health Sciences Centre. It's copied to
20 yourself and Dr. Williams, you as the clinical
21 chief, Dr. Williams as the VP. And Dr.
22 Fontaine here, Doctor, begins by addressing
23 Mr. Gulliver by saying "I write to you in
24 response to the recent problems experienced
25 with the immunohistochemical staining,

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1 specifically regarding estrogen and
2 progesterone receptors. It is my opinion that
3 the problem extends far beyond the estrogen
4 and progesterone receptor status, as has been
5 identified." And he goes on then to speak
6 about bringing the lab to a standard whereby a
7 confident diagnosis can be delivered on the
8 basis of IHC staining, which is key to an
9 accurate diagnosis and patient management. A
10 dedicated IHC lab is essential." And he goes
11 on at some length. In the second paragraph,
12 he says, "With respect to our institution,
13 fixation is the key component of IHC staining.
14 At the current time there is a variety of
15 practice patterns involving various
16 pathologists, to which there is no
17 standardized approach to grossing of
18 specimens." And he suggests "this is best
19 remedied by the introduction of pathology
20 assistance into the program."
21 DR. COOK:
22 A. Uh-hm.
23 COFFEY, Q.C.:
24 Q. And notes that "it is standard practice at all
25 other tertiary care academic centres." And

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1 the next page, and there's much more written
2 there, I'm not going to explicitly refer to,
3 but he goes on about the pathology assistants,
4 another benefit of them would be to make
5 better use of the Sekura Tech Express and he
6 says, "in attempting to introduce this
7 technology to the Health Sciences, the
8 pathologists have been hesitant in adopting
9 the new technique as this involves a change in
10 grossing practice, resulting in a more
11 laborious process. Although the end result is
12 satisfactory, the pathologists do not feel
13 that their time is well spent to deliver such
14 technically challenging sections." And he
15 concludes by saying, "It is my opinion these
16 are essential changes for the Department to
17 meet national standards, as the two are key
18 components of a fully functioning and
19 standardized lab." And I should to put it
20 fully in perspective, in his first paragraph
21 of his first page, he concludes that paragraph
22 by saying, "In order to carry out this
23 service"--that's the IHC service--"we would
24 require a minimum of two dedicated
25 technologists to the IHC service."

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1 DR. COOK:
2 A. Uh-hm.
3 COFFEY, Q.C.:
4 Q. Now did you have any forewarning that Dr. Dan
5 Fontaine was going to write this?
6 DR. COOK:
7 A. We did discuss the need for pathology
8 assistants and his reference there to the HAY
9 report is what I provided to him and I
10 actually had him see a copy of the HAY report
11 back in '02 whereby there was a recommendation
12 for pathology assistants, so we obviously--I
13 remember having conversations with Dr.
14 Fontaine about the need for a dedicated
15 immunohisto techs, the need for pathology
16 assistants to help us in the standardization
17 of the gross cutting of the specimens. And to
18 facilitate the Sekura Express.
19 COFFEY, Q.C.:
20 Q. Now, Doctor, in the past, I mean up to this
21 point, September 2005, people involved had
22 been pushing pathology assistants as a back
23 up.
24 DR. COOK:
25 A. That's correct.

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1 COFFEY, Q.C.:
2 Q. What had been the problem?
3 DR. COOK:
4 A. The problem was the lack of consistency from
5 pathologist to pathologist in taking their
6 sections.
7 COFFEY, Q.C.:
8 Q. And the pathology assistants, as Dr. Fontaine
9 points out here, might remedy that because you
10 had very few people doing the grossing.
11 DR. COOK:
12 A. Yes, if you had a core group of people doing
13 the gross examinations, the sectionings and
14 whatnot, by a core group, I mean a group of
15 three or four, and had them trained, you're
16 going to get a much more standardized product.
17 COFFEY, Q.C.:
18 Q. Who or what had been the obstacles to having
19 pathology assistants then?
20 DR. COOK:
21 A. Finances, money.
22 COFFEY, Q.C.:
23 Q. And in the period of four or five years before
24 this, if somebody was to find the money to do
25 it, who would have had to have pushed it?

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1 DR. COOK:
2 A. I would have pushed it.
3 COFFEY, Q.C.:
4 Q. And I appreciate you did and others, who above
5 you would have had to have pushed it?
6 DR. COOK:
7 A. Oh, Dr. Williams.
8 COFFEY, Q.C.:
9 Q. And I take it that would be with Mr. Tilley, I
10 take it?
11 DR. COOK:
12 A. Mr. Tilley and executive committee.
13 COFFEY, Q.C.:
14 Q. Your understanding was it hadn't happened
15 because of what?
16 DR. COOK:
17 A. Simply no money.
18 COFFEY, Q.C.:
19 Q. How much more money was involved, do you know?
20 DR. COOK:
21 A. A pathology assistant would make approximately
22 60 to $70,000 a year, probably in 2002, 2003,
23 you're looking at 60,000. So it would have
24 been about $240,000 to bring in pathology
25 assistants for salaries.

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1 COFFEY, Q.C.:
2 Q. Would there have been any personnel savings as
3 a result of having them?
4 DR. COOK:
5 A. It would have been greater efficiency for the
6 pathologists in that they would have had more
7 time to devote to their microscopic
8 evaluations and teachings and research, that
9 sort of thing. They, in terms of efficiency,
10 the efficiency would mainly be on the
11 professional end in freeing up pathology time.
12 It probably would have been cheaper to bring
13 in a couple of pathology assistants than
14 hiring extra pathologists.
15 COFFEY, Q.C.:
16 Q. Yes. Doctor, now Dr. Banerjee assuredly did
17 arrive in mid September.
18 DR. COOK:
19 A. Uh-hm.
20 COFFEY, Q.C.:
21 Q. What do you recall about his visit?
22 DR. COOK:
23 A. Well, he was here for two days, I picked him
24 up at the Hotel Newfoundland and drove him to
25 St. Clare's and one of the things that Dr.

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1 Banerjee wanted me to do was to set up a
2 number of slides that he could review our
3 original ERs and PRs, as well, set up, have
4 him review a number of slides from our other
5 IHC tests, so the number of ERs and PRs I
6 think were approximately about 20 cases, if I
7 remember, and they were primarily chosen from
8 the original samples of the 25 and 33 batch,
9 as well as others from the general ER/PR pool.
10 So I believe there were both positives and
11 negatives there. In terms of the other IHC
12 testing, those were randomly chosen, I would
13 give my secretary a list of IHC stains that I
14 would want to see, there could be stains such
15 as LCA, CK7, 20, synaptophysin, chromogranin,
16 run of the mill stains that we were using on a
17 daily basis. She would enter those in the
18 computer and randomly draw cases from which
19 those stains belonged to. So that's how that
20 particular part was chosen.
21 COFFEY, Q.C.:
22 Q. Go ahead, and what happened?
23 DR. COOK:
24 A. So that morning, both myself and Dr. Banerjee
25 sat at the multi-headed scope in the

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1 laboratory at St. Clare's and I started off by
2 showing him our ER and PR stains. Most of the
3 initial conversation was made by myself, where
4 I expressed my observations over what I saw.
5 So first when I would show up the stains, and
6 these were the negative stains, I remember
7 Diponkar's first suggestion was that the
8 problem lay with antigen retrieval, that was
9 his -
10 COFFEY, Q.C.:
11 Q. What does that actually mean then?
12 DR. COOK:
13 A. Well that was a process, a technical process,
14 where antigen retrieval would result in the
15 unmasking of the crosslinks of the proteins
16 covering the antigen site, and that occurred
17 as a result of formalin fixation. So if you
18 have good antigen retrieval with proper
19 incubation times and temperatures and proper
20 antibody concentrations, you would have those
21 crosslinks eliminated and the primary antibody
22 would come in and to attach to the antigen
23 site.
24 COFFEY, Q.C.:
25 Q. That's actually what antigen retrieval is, but

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1 what--in terms of the problem -
2 DR. COOK:
3 A. That's where he thought initially the problem
4 could be.
5 COFFEY, Q.C.:
6 Q. What would be the nature of the problem?
7 DR. COOK:
8 A. That there was a failure in the antigen
9 retrieval.
10 COFFEY, Q.C.:
11 Q. Did he elaborate on why that might be so?
12 DR. COOK:
13 A. No, he just made that comment that that could
14 be where the problem lay.
15 COFFEY, Q.C.:
16 Q. Did you ask him at the time, you know, bearing
17 in mind you were both there, how he knew that
18 just looking through the scope?
19 DR. COOK:
20 A. No, that was his first comment that he made.
21 COFFEY, Q.C.:
22 Q. Did you ask him though?
23 DR. COOK:
24 A. No, I didn't ask him.
25 COFFEY, Q.C.:

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1 Q. Did you ever ask him about how he was able to
2 tell that?
3 DR. COOK:
4 A. No.
5 COFFEY, Q.C.:
6 Q. I'm sorry, go ahead, Doctor.
7 DR. COOK:
8 A. Then we went through the slides and we talked
9 about the fixation, I brought his attention to
10 the fixation, how there are variable amounts
11 of fixation problems with the slides. In some
12 of the slides were minor fixation problems,
13 some were a bit more major in nature. And
14 talked to him about how pathologists were
15 grossing and I brought that up that the
16 pathologists were all grossing their own
17 sections. And we began discussing the need
18 for pathology assistants in that if we had
19 pathology assistants, there would be more much
20 attention made to the fixation issue, there
21 would be much more attention made to the
22 sectioning of the specimen, the depth of the
23 specimen, et cetera, so we were basically
24 discussing the significant and important role
25 of pathology assistants and had we had these

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1 in place, I was saying to Banerjee that--Dr.
2 Banerjee, that this surely would have made a
3 difference in to how the tissue blocks had
4 been sectioned and monitored, in terms of
5 fixation.
6 COFFEY, Q.C.:
7 Q. Go ahead.
8 DR. COOK:
9 A. So those were general comments and then we
10 looked at the internal controls. A number of
11 cases had very small rims of normal tissue
12 surrounding the tumour; other cases we had
13 trouble identifying positivity of cells into
14 the internal controls, and don't forget, we
15 were moving through these rather quickly
16 because I was flipping through them, wanted
17 him to see as many of the slides as he could
18 see in the time allotted. So that was an
19 observation that I made and he agreed with
20 that observation.
21 COFFEY, Q.C.:
22 Q. I'm sorry, it was an observation you made and
23 he agreed?
24 DR. COOK:
25 A. Yes, yes.

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1 COFFEY, Q.C.:
2 Q. So this was something that you had figured out
3 on your own, before Dr. Banerjee ever showed
4 up?
5 DR. COOK:
6 A. Right, myself and Dr. Carter.
7 COFFEY, Q.C.:
8 Q. Okay, go ahead. I apologize, Doctor, this
9 would have been back in July?
10 DR. COOK:
11 A. Yes, around late July.
12 COFFEY, Q.C.:
13 Q. Okay, go ahead Doctor.
14 DR. COOK:
15 A. So we went to the internal controls and there
16 was another issue we were talking about, I'm
17 trying to remember now, then we went on to
18 the--oh, we talked about the need for
19 subspecialization and I brought that up, we
20 had general discussion about the stability
21 problems we had in manpower areas and my
22 opinion was that if we had been able to
23 subspecialize into subspecialty groups, it is
24 possible that we could have picked up this
25 issue earlier, so we spoke about trends and

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1 whatnot. The next thing I remember, I was
2 going through the various immunohistochemical
3 stains and slides from the other tests, the
4 synaptophysin, chromogranin and whatnot. So
5 again, I was going through these very quickly
6 we were looking both at the H&E's and then
7 correlating that with the immunohistochemical
8 stains. So this went on, I'd say probably
9 two, two and a half hours, three hours, going
10 through this sort of a conversation back and
11 forth. And when he was finished, he made the
12 observation and this is where the observation
13 about the middle of the pack came in, that in
14 his opinion, he had seen many slides from many
15 other institutions across Canada, in his
16 opinion, our slides were in the middle of the
17 pack.
18 COFFEY, Q.C.:
19 Q. And slides in what sense, what type of slides?
20 DR. COOK:
21 A. In terms of quality, these were the IHC
22 slides.
23 COFFEY, Q.C.:
24 Q. So middle of the pack would refer to IHC
25 slides in general?

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1 DR. COOK:
2 A. Yes.
3 COFFEY, Q.C.:
4 Q. Not that comment would not have been limited
5 in your understanding to ER and PR, it would
6 have been all IHC slides?
7 DR. COOK:
8 A. Yes, after showing--that was my
9 interpretation, the ERs and PRs and the other
10 IHC tests.
11 COFFEY, Q.C.:
12 Q. And middle of the pack in what sense?
13 DR. COOK:
14 A. In terms of quality, when we were going
15 through the various slides, Dr. Banerjee would
16 make a comment about this slide is below
17 average, average, above average, this sort of
18 comments being made as I was flipping through
19 the various slides.
20 COFFEY, Q.C.:
21 Q. Okay, was that aspect of the matter ever
22 discussed between the two of you again?
23 DR. COOK:
24 A. It was or it was brought up at the exit
25 meeting the next day with Dr. Williams,

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1 myself, I think Mr. Gulliver were there -
2 COFFEY, Q.C.:
3 Q. I'll come to that in a moment then, so that
4 day you have a multi-hour session with Dr.
5 Banerjee.
6 DR. COOK:
7 A. Uh-hm.
8 COFFEY, Q.C.:
9 Q. What then happened during his visit?
10 DR. COOK:
11 A. I think after that three-hour period, we went
12 out for lunch. Myself, Dr. Denic, who was
13 president of the NAP at the time, and Dr.
14 Banerjee. We had some more general discussion
15 about the manpower situation in Canada, the
16 shortages that we were experiencing, the
17 impact on Newfoundland. It was at that time,
18 I believe, that Dr. Denic asked Dr. Banerjee
19 would he mind writing a letter to the
20 Provincial Government supporting or advocating
21 on our behalf the need for increased salaries
22 for Newfoundland pathologists. So following
23 that, I brought him to General Hospital where
24 I had--I introduced him to a number of
25 individuals, the first individuals were Mr.

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1 Dyer and Mr. Gulliver and I arranged to have
2 meetings set up with Dr. Ejeckam, Dr.
3 Fontaine, I believe there were meetings too
4 with the technologists. And after that, I
5 left and it was Dr. Fontaine, I believe who
6 then brought him back to the Fairmont, took
7 him out for dinner later on that night. The
8 next morning or the next day, I'm not sure if
9 he continued on with his review, certainly
10 around the Friday of mid-day, we had the exit
11 interview.
12 COFFEY, Q.C.:
13 Q. And you were about to tell me about that, go
14 ahead?
15 DR. COOK:
16 A. Well then this is where this comment again,
17 about the middle of the pack came up, at the
18 meeting with myself and Dr. Williams, I think
19 Mr. Gulliver was there, I'm not sure if
20 Heather Predham was there and we talked about
21 the issue for, general issues regarding the
22 need for pathology assistants, the need to do
23 something with our manpower situation, the
24 need to subspecialize, the need to have
25 greater documentation, particularly in the

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1 technical aspect of the lab. There was praise
2 given for our managers, there was issues -
3 COFFEY, Q.C.:
4 Q. Which managers were they?
5 DR. COOK:
6 A. Mr. Gulliver and Mr. Dyer, he felt they were
7 working hard. There were issues, again,
8 surrounding the management structure. So that
9 sort of thing was some of the items being
10 discussed.
11 COFFEY, Q.C.:
12 Q. And anything else that you can recall about
13 that?
14 DR. COOK:
15 A. Not unless I looked at my notes, that's the
16 best that I can recall offhand.
17 COFFEY, Q.C.:
18 Q. Mr. Browne, top of your head, his notes?
19 MR. BROWNE:
20 Q. (Inaudible).
21 THE COMMISSIONER:
22 Q. It's about time for the afternoon break. Do
23 you want me to take the break and then you can
24 locate that particular number?
25 COFFEY, Q.C.:

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1 Q. Thank you very much.
2 (RECESS)
3 THE COMMISSIONER:
4 Q. Please be seated. Mr. Coffey.
5 COFFEY, Q.C.:
6 Q. Yes, Commissioner, Doctor I will, in several
7 minutes, have available on the computer system
8 for you, okay, the exit interview notes, but
9 other than the exit interview then and the
10 communications that you've described during
11 the first day that Dr. Banerjee was here in
12 September, 2005, did you have any other
13 interaction with him?
14 DR. COOK:
15 A. Dr. Banerjee?
16 COFFEY, Q.C.:
17 Q. Yes.
18 COFFEY, Q.C.:
19 Q. You did the exit interview and took notes -
20 DR. COOK:
21 A. I can't recall any other interview.
22 COFFEY, Q.C.:
23 Q. Okay. And if we could, please, Exhibit P-
24 0046? Now, Dr. Cook, this is a letter of
25 October 17th, 2005 from Dr. Banerjee to

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1 yourself. The subject is "External Quality
2 Review of the Immunohistochemistry Service".
3 Of course, attached to this is a copy of his,
4 I apologize, his actual report dated October
5 17th, 2005.
6 DR. COOK:
7 A. Uh-hm.
8 COFFEY, Q.C.:
9 Q. So you received this report then within a day
10 or two of October 17th, 2005 or within a week
11 anyway?
12 DR. COOK:
13 A. Well I wouldn't know the exact date I received
14 it.
15 COFFEY, Q.C.:
16 Q. When you received it, Doctor, did you review
17 it?
18 DR. COOK:
19 A. I read through it rather quickly at the time.
20 COFFEY, Q.C.:
21 Q. Yes.
22 DR. COOK:
23 A. And then I contacted Dr. Williams that I had
24 the report and I brought it over to him within
25 30 to 45 minutes of my receipt of the report.

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1 COFFEY, Q.C.:
2 Q. And what happened then?
3 DR. COOK:
4 A. I basically had some general conversation with
5 Dr. Williams regarding the contents of the
6 report and concerning issues that Dr. Banerjee
7 had identified, issues regarding the
8 pathologists and the state of the slides and
9 how these were reported, et cetera.
10 COFFEY, Q.C.:
11 Q. Do you recall what that conversation was?
12 DR. COOK:
13 A. I can't recall the specifics of that
14 conversation, I know that Dr. Williams wanted
15 to review the report in detail.
16 COFFEY, Q.C.:
17 Q. And what then happened in relation to this
18 matter of the report?
19 DR. COOK:
20 A. I then think we went back and had a more
21 detailed discussion on the contents of the
22 report, particularly on the phone, the
23 implication for pathologists and the issues of
24 internal controls, the issues of our high turn
25 over, the issues of the reporting mechanism,

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1 the management structure, issues of that
2 nature.
3 COFFEY, Q.C.:
4 Q. Now, Doctor, when you had a chance to read Dr.
5 Banerjee's report, I take it carefully, which
6 would be after the initial meeting with Dr.
7 Williams.
8 DR. COOK:
9 A. Uh-hm.
10 COFFEY, Q.C.:
11 Q. Did you take any issue with what he said in
12 his report?
13 DR. COOK:
14 A. Generally no, I agreed with many of the
15 contents of the report, the comment there
16 about the thickness of the tissue sections, I
17 don't know how you could have made a comment
18 about that, just looking at the slides.
19 COFFEY, Q.C.:
20 Q. Okay, and that would be, Doctor, go ahead,
21 Doctor with the mouse, if you like, you can
22 just point where that is to the Commissioner?
23 DR. COOK:
24 A. This right here, I think.
25 THE COMMISSIONER:

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1 Q. (inaudible) slide?
2 DR. COOK:
3 A. There's a comment there about the thickness.
4 THE COMMISSIONER:
5 Q. There's a reference on the--right there, on
6 the bottom of page two, I don't know if that's
7 what you're referring to?
8 DR. COOK:
9 A. Yeah, that comment there.
10 COFFEY, Q.C.:
11 Q. It says here, "fixation time in formalin does
12 not affect the ER results as long as two
13 millimetre thick slices of tissue are placed
14 in fixative within 15 minutes of surgical
15 excision. Inadequate heat induced antigen
16 retrieval is performed" and then he has a
17 footnote, "however the effects of under
18 fixation due to greater than two millimetre
19 thick slices remains a possibility."
20 DR. COOK:
21 A. Yeah, I mean when you consider that our
22 paraffin blocks are no more than about three
23 millimetres, most of our tissue sections would
24 be around two millimetres or so, so I didn't
25 know how he could make that statement.

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1 COFFEY, Q.C.:
2 Q. And I take it that was based upon looking at
3 the slides?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. Do you know whether or not he otherwise though
8 when he visited, for example, the General
9 Hospital's pathology lab -
10 DR. COOK:
11 A. He did.
12 COFFEY, Q.C.:
13 Q. Would it be possible that there was based upon
14 some observations that he may or may not have
15 made there?
16 DR. COOK:
17 A. It's possible.
18 COFFEY, Q.C.:
19 Q. So that's one thing you were concerned about.
20 Did you ever take that up with him?
21 DR. COOK:
22 A. No.
23 COFFEY, Q.C.:
24 Q. Anything else, Doctor?
25 DR. COOK:

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1 A. No, for the most part I agreed with the
2 report. I thought the report was good, it was
3 exactly what I was looking for, exactly what I
4 needed to bring this to administration to put
5 forth the views and the issues and the
6 problems that, certainly some of the problems
7 anyway, that I had been experiencing as a
8 clinical chief in the Laboratory Medicine
9 Program.
10 COFFEY, Q.C.:
11 Q. And, so Doctor, other than that one comment,
12 the one you pointed out, the greater than two
13 millimetre thick slices, you otherwise agreed
14 with the rest of it?
15 DR. COOK:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. As well, but of course, he does have a number
19 of recommendations, there are ten of them
20 listed and you were, I take it, in agreement
21 with those?
22 DR. COOK:
23 A. Yes.
24 COFFEY, Q.C.:
25 Q. Doctor, having read Dr. Banerjee's report, was

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1 it your view that the problem with the ER and
2 PR testing could have been detected earlier?
3 DR. COOK:
4 A. To my view, yes.
5 COFFEY, Q.C.:
6 Q. And detected by whom and at what stages, and
7 for what reason?
8 DR. COOK:
9 A. Well, I strongly believe that if we had
10 stability in the manpower--not only stability
11 in the manpower, but the mind sight amongst
12 ourselves that we had a stable core of
13 pathologists, I think we would have headed in
14 the direction of subspecialization.
15 Subspecialization, I think, we would have had
16 a small group of pathologists dedicated to
17 breast pathology, looking at issues
18 surrounding breast pathology and developing a
19 quality assurance program surrounding
20 subspecialization, as opposed to the
21 generalist quality assurance program and
22 quality assurance activities that we had.
23 Now by subspecialization, I don't mean
24 all pathologists in a particular subgroup
25 would be just dedicated to a particular group.

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1 You would have, say, a subspecialist trained
2 pathologist with two or three other generalist
3 trained pathologists to focus on, for
4 instance, breast pathology. Much of the
5 breast pathology is relatively
6 straightforward, 90 to 95 percent, but it's
7 those five percent of cases that you need a
8 subspecialist and subspecialist's opinion.
9 COFFEY, Q.C.:
10 Q. Doctor, looking at the heading "conclusions
11 about reasons for test failure" on page three,
12 continuing into page four, in paragraph three,
13 he says "is there a problem with"--well,
14 paragraph one, I take it he posits that it's
15 unlikely that the DAKO system was faulty.
16 DR. COOK:
17 A. That's his opinion, yeah.
18 COFFEY, Q.C.:
19 Q. And do you have any reason to believe that the
20 DAKO system itself was faulty?
21 DR. COOK:
22 A. Nothing to suggest something system wide with
23 the DAKO. There were a few incidents, as I
24 said in my testimony yesterday, that indicated
25 some problems with antibody expression, pump

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1 failure, but to my knowledge -
2 COFFEY, Q.C.:
3 Q. That was reported elsewhere, I take -
4 DR. COOK:
5 A. That was reported elsewhere, from other areas.
6 To my knowledge, I don't know of any system
7 wide failure with the DAKO system. It's
8 unfortunate that we don't--we didn't have our
9 original DAKO machine to go back and retest.
10 COFFEY, Q.C.:
11 Q. He then, in paragraph two, says "is the
12 Ventana system too sensitive? There's no
13 evidence that the Ventana system creates false
14 positive results."
15 DR. COOK:
16 A. Um-hm.
17 COFFEY, Q.C.:
18 Q. So I take it then that, as you've indicated,
19 you didn't take any issue with this, his
20 report, the contents of his report, so the
21 Ventana system wasn't the problem?
22 DR. COOK:
23 A. That's correct.
24 COFFEY, Q.C.:
25 Q. Paragraph three, "is there a problem with

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1 tissue fixation?" and he says "there appears
2 to be inadequate attention paid by the
3 grossing pathologists to the thickness of
4 tissue slices, quality and adequacy of
5 fixation, and there's no standardized fixation
6 protocol that everyone adheres to."
7 DR. COOK:
8 A. Um-hm.
9 COFFEY, Q.C.:
10 Q. So the idea of having a standardized fixation
11 protocol, I take it, is a good idea?
12 DR. COOK:
13 A. That, along with pathologist assistants. This
14 is the main point. When I look at tissue
15 fixation, I equate that with pathology
16 assistants.
17 COFFEY, Q.C.:
18 Q. And if there's a problem with tissue fixation,
19 this should be--it's the sort of problem that
20 should be recognized by the pathologists
21 looking through the scope?
22 DR. COOK:
23 A. Pathology and along with pathology assistants
24 to make sure that the tissue comes down--they
25 would keep a track on tissue that originates

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1 from the OR. They would retrieve it
2 themselves. They would section it in a
3 certain fashion. They would be aware with
4 fixation and fixation protocols.
5 COFFEY, Q.C.:
6 Q. I take it though before--in the absence of
7 pathology assistants, that's a pathologist's
8 job?
9 DR. COOK:
10 A. It is, but I'm saying that if we had to have
11 pathology assistants, we would have had a
12 standardized way of sectioning these specimens
13 and with a good surveillance program for the
14 tissue fixation.
15 COFFEY, Q.C.:
16 Q. Couldn't there have been a standardized
17 fixation protocol that applied to the
18 pathologists as a whole?
19 DR. COOK:
20 A. That's fine, Mr. Coffey. You can have
21 standardized fixation protocols, but the
22 nature of it is when you have 20 or 30
23 pathologists coming in and out of the lab,
24 doing this sectioning, you're still not going
25 to get the same standardization if you have a

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1 core group of pathology assistants.
2 COFFEY, Q.C.:
3 Q. And if there is a problem with tissue that's
4 apparent in looking through the scope, I take
5 it that, a microscope, that that's--if the
6 problem, fixation problem is sufficient to
7 affect the result, if that's to be caught by
8 anyone, it would be caught by the
9 pathologists?
10 DR. COOK:
11 A. It would be caught by the pathologist, but the
12 degree of fixation problems, I firmly believe,
13 would have been handled by pathology
14 assistants.
15 COFFEY, Q.C.:
16 Q. There's a reference, paragraph four,
17 "inadequate or no attention is being paid by
18 the reporting pathologist to the status of
19 internal controls."
20 DR. COOK:
21 A. Um-hm.
22 COFFEY, Q.C.:
23 Q. So had you, in fact, already concluded that?
24 DR. COOK:
25 A. Yes.

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1 COFFEY, Q.C.:
2 Q. From your perspective, should a pathologist
3 who is reading an ER and PR slides have known
4 to pay attention to internal controls?
5 DR. COOK:
6 A. They should have paid attention and there, Mr.
7 Coffey, if we had to have subspecialization, I
8 am absolutely sure we would have picked this
9 up earlier.
10 COFFEY, Q.C.:
11 Q. Do you think that the knowledge concerning
12 internal controls would be limited to a
13 subspecialist?
14 DR. COOK:
15 A. I don't know, Mr. Coffey. I can't answer that
16 question what every pathologist thinks.
17 COFFEY, Q.C.:
18 Q. Well, you had been aware of it, you've told us
19 yesterday or the day before, since 2000.
20 DR. COOK:
21 A. Around there, yes.
22 COFFEY, Q.C.:
23 Q. So I take it it was--if someone went looking
24 for it, a pathologist went looking for it, it
25 was probably readily ascertainable at least as

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1 early as 2000?
2 DR. COOK:
3 A. Again, I can't say what each pathologist
4 thinks or what -
5 COFFEY, Q.C.:
6 Q. Was it readily ascertainable as a pathologist
7 as early as 2000?
8 DR. COOK:
9 A. Yes, it was.
10 COFFEY, Q.C.:
11 Q. Do you know if it was readily ascertainable
12 before that?
13 DR. COOK:
14 A. Possibly.
15 COFFEY, Q.C.:
16 Q. Have you ever asked any of your fellow
17 pathologists about their knowledge of internal
18 controls or lack of knowledge about internal
19 controls?
20 DR. COOK:
21 A. I have.
22 COFFEY, Q.C.:
23 Q. And what have you been--when did that happen
24 and who did you speak to, and what were you
25 told?

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1 DR. COOK:
2 A. I spoke to a number of pathologists, certainly
3 around this time period. Again, these would
4 be pathologists outside of St. John's and
5 inside of St. John's. There are some who have
6 expressed to me that they had knowledge of
7 internal controls. Most have indicated that
8 they didn't rely on internal controls.
9 COFFEY, Q.C.:
10 Q. I'm sorry?
11 DR. COOK:
12 A. Most.
13 COFFEY, Q.C.:
14 Q. Indicated they?
15 DR. COOK:
16 A. Hadn't relied on internal control.
17 COFFEY, Q.C.:
18 Q. Hadn't?
19 DR. COOK:
20 A. Had not.
21 COFFEY, Q.C.:
22 Q. Had they been aware of them?
23 DR. COOK:
24 A. I don't think they were aware of it.
25 COFFEY, Q.C.:

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1 Q. Was there any discussion amongst any of those
2 individuals about Dr. Ejeckam's May 2nd, 2003
3 memo?
4 DR. COOK:
5 A. No.
6 COFFEY, Q.C.:
7 Q. Now, Doctor, you've indicated just now that
8 you did, after getting this report, did speak
9 to pathologists about it.
10 DR. COOK:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. Do you recall when and where that was and what
14 happened?
15 DR. COOK:
16 A. Well, Mr. Coffey, that was to a number of
17 pathologists in a number of different
18 locations, at the General, St. Clare's, in
19 offices, in corridors, that sort of thing.
20 Now there was a meeting that I held with the
21 pathologists regarding this report.
22 COFFEY, Q.C.:
23 Q. Yes.
24 DR. COOK:
25 A. Do you want me to get into that?

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1 COFFEY, Q.C.:
2 Q. Yes, if you would, please?
3 DR. COOK:
4 A. That was a meeting that I had sometime early
5 or mid November, I believe. I got permission
6 from Dr. Williams to comment on the contents
7 of this report, and that took place at Lecture
8 Theatre D sometime in November, I believe, of
9 2005. There, we had quite a number of
10 pathologists, from both the St. Clare's and
11 the General Hospital site. I read out the
12 entire contents, word for word, of Dr.
13 Banerjee's report to the pathologists. Issues
14 that were highlighted include the issue of
15 internal controls, issues of fixation, issues
16 of our high turnover, issues of reporting.
17 These were the main issues that were basically
18 highlighted in that discussion, if I remember,
19 with our pathologists.
20 COFFEY, Q.C.:
21 Q. Do you recall--so you met with them. It was
22 for this purpose, I take it, to discuss the
23 report?
24 DR. COOK:
25 A. Yeah.

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1 COFFEY, Q.C.:
2 Q. You read out the entire report to them?
3 DR. COOK:
4 A. Um-hm.
5 COFFEY, Q.C.:
6 Q. Did you tell them anything else, do you
7 recall?
8 DR. COOK:
9 A. There could have been issues surrounding our
10 management structure, issues--again, I
11 highlighted the efforts of the program
12 director and divisional manager. So those
13 basically were the main issues that I brought
14 forth.
15 COFFEY, Q.C.:
16 Q. What was their reaction or feedback on this?
17 DR. COOK:
18 A. It was--the room became very quiet. There was
19 very little feedback, if I remember correctly,
20 initially. When I started talking about
21 subspecialization and my feelings on that and
22 how I think that this could have picked up
23 from a lot earlier, there was a lot of general
24 discussion about the turnover and the lack of
25 stability in the organization, issues that we

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1 had over the last years with restructuring,
2 constant upheaval in the organization,
3 manpower issues, workload issues. Those were
4 basically issues surrounding my discussion
5 with the pathologists.
6 COFFEY, Q.C.:
7 Q. How about afterward, Doctor, did you ever talk
8 to any of the pathologists afterward about
9 this?
10 DR. COOK:
11 A. I might have, Mr. Coffey, from time to time,
12 on different things. There was a lot of
13 discussion with individuals at different time
14 periods, at different sites.
15 COFFEY, Q.C.:
16 Q. Here, Doctor, just looking at this, just want
17 to clarify this, the reference on the first
18 page of text, under heading "review of cases"
19 the doctor writes "I reviewed a number of
20 cases from the retrospective testing set with
21 Dr. Donald Cook. All of the cases that had
22 converted from negative to positive by
23 switching platforms had one or more of the
24 following characteristics."
25 DR. COOK:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. And then he spells it out, one, two, three.
4 DR. COOK:
5 A. Right.
6 COFFEY, Q.C.:
7 Q. Those, the number of cases from the
8 retrospective testing set with Dr. Donald
9 Cook, and then all the cases that had
10 converted, negative to positive. Which cases
11 were they that you showed him?
12 DR. COOK:
13 A. Those were mainly cases from St. John's area.
14 COFFEY, Q.C.:
15 Q. And do you recall which grouping they were?
16 Because when we look above, and the reason I
17 ask that is the paragraph above refers to
18 "this led to a review of other 57 cases
19 reported in 2002 as negative which was retest-
20 -which on retesting on the Ventana resulted in
21 a high conversion rate from negative to
22 positive, 38 out of 57, 67 percent."
23 DR. COOK:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. Do you know if Dr. Banerjee saw the original
2 slides for those 38?
3 DR. COOK:
4 A. He may have saw some of those. I can't be
5 absolutely sure, but it's possible he saw some
6 of the original slides from that grouping.
7 It's possible. I can't say for sure.
8 COFFEY, Q.C.:
9 Q. So which slides he actually saw, you know he
10 saw some original ER/PR slides?
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. That on retesting had converted?
15 DR. COOK:
16 A. That's right.
17 COFFEY, Q.C.:
18 Q. The sample had, but which ones, there was--
19 there was no record kept, I take it?
20 DR. COOK:
21 A. Oh no, I wish I had kept a record, but I
22 didn't.
23 COFFEY, Q.C.:
24 Q. Okay. Doctor, I understand that Dr. Banerjee
25 returned to St. John's in, I believe, April of

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1 2006?
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. Were you involved in that?
6 DR. COOK:
7 A. I was involved in meeting with him and I was
8 involved, I believe, with his exit interview.
9 I did not get a copy of his report. That was
10 forwarded on to Dr. Denic.
11 COFFEY, Q.C.:
12 Q. Did you subsequently see a copy of that
13 report?
14 DR. COOK:
15 A. I have.
16 COFFEY, Q.C.:
17 Q. And when was that?
18 DR. COOK:
19 A. That was sometime, I believe, a few months
20 after Dr. Denic had received it. I can't tell
21 exactly when I got it.
22 COFFEY, Q.C.:
23 Q. So it was sometime, probably during 2006?
24 DR. COOK:
25 A. Possibly, yes.

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1 COFFEY, Q.C.:
2 Q. Okay. If we could, Commissioner, just because
3 the Doctor had referred to it, could I ask
4 that Exhibit P-2148 be entered please?
5 THE COMMISSIONER:
6 Q. Sorry?
7 COFFEY, Q.C.:
8 Q. 2148, I apologize, Commissioner.
9 THE COMMISSIONER:
10 Q. 2140?
11 COFFEY, Q.C.:
12 Q. 2148.
13 THE COMMISSIONER:
14 Q. Entered.
15 EXHIBIT ENTERED AND MARKED EXHIBIT P-2148
16 COFFEY, Q.C.:
17 Q. And Registrar, if you would, please, when you
18 have a chance? And these, I take it, are your
19 exit notes, Doctor, of September 16th, 2005,
20 external review, the exit interview of Dr.
21 Banerjee?
22 DR. COOK:
23 A. Yeah.
24 COFFEY, Q.C.:
25 Q. Is there anything here, just looking down

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1 through this, Doctor, that--because you were
2 describing it to me earlier, your memory of
3 it, anything that we have not covered that -
4 DR. COOK:
5 A. Well, you know, as I distinctly remember
6 sitting with the multi-headed scope, we
7 referred to the slides as being in the middle
8 of the pack. Now there, I got comparable
9 service. Now he may have said service at the
10 time of his exit interview, but I can
11 certainly remember him saying slides. Do you
12 want me to read it out?
13 COFFEY, Q.C.:
14 Q. If you would, please, Doctor, because it is
15 your handwriting, and at times -
16 DR. COOK:
17 A. Yes.
18 COFFEY, Q.C.:
19 Q. - it can be a bit difficult.
20 DR. COOK:
21 A. "In terms of the immunohistochemical stains
22 providing a comparable service with the rest
23 of Canada, in some areas we were above. There
24 is lots of potential in the division of -
25 COFFEY, Q.C.:

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1 Q. I'm sorry, actually "we are above average"
2 actually it says, isn't it?
3 DR. COOK:
4 A. Above average, sorry. "There is lots of
5 potential in the division of anatomical
6 pathology with both pathologists and managers
7 wanting to achieve the same end point, that of
8 a good quality, reliable service. There are
9 issues, front line issues concerning adequate
10 fixation of tissue which can affect the
11 reliability of immunoperoxidase testing. The
12 need for pathology assistants to ensure that
13 specimens and sections are processed in a
14 standardized manner. Use of front line
15 fixation would be difficult to overcome
16 considering tissue coming in from out of town.
17 The need for highly specialized -
18 COFFEY, Q.C.:
19 Q. That should be "come in from all over the
20 province"
21 DR. COOK:
22 A. All over the province, sorry. "The need for
23 highly specialized immunoperoxidase service
24 with technologists dedicated for
25 immunoperoxidase testing. Troubleshooting.

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1 Issue of proper documentation and antigen
2 retrieval methodology. The need for
3 subspecialization with an adequate
4 compensation package and concerns about a
5 manpower problem. No matter how good you are
6 in providing the service, it is not if the
7 pathology is up to par."
8 COFFEY, Q.C.:
9 Q. "No matter how good your oncology"
10 DR. COOK:
11 A. Oh, sorry, oncology service.
12 COFFEY, Q.C.:
13 Q. Is that oncology service?
14 DR. COOK:
15 A. Yeah, "if pathology is not up to par."
16 COFFEY, Q.C.:
17 Q. So that, I take it, was a comment by him to
18 the effect that oncologists, to be effective,
19 need good pathology?
20 DR. COOK:
21 A. Yes.
22 COFFEY, Q.C.:
23 Q. Trish Wegrynowski, I take it, came to St.
24 John's as well in September 2005?
25 DR. COOK:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. Did you have any interaction with her?
4 DR. COOK:
5 A. Very little. Had an hour meeting with her
6 with Dr. Carter and myself, and possibly an
7 exit interview the next day. Trish was mainly
8 looking at the technical aspect and that would
9 have been under Mr. Gulliver and Dyer, while I
10 concentrated the medical aspect with Dr.
11 Banerjee.
12 COFFEY, Q.C.:
13 Q. And do you recall--what, if anything, do you
14 recall about her--did you attend her exit
15 interview?
16 DR. COOK:
17 A. Yes, I did.
18 COFFEY, Q.C.:
19 Q. What, if anything, do you recall about that,
20 Doctor?
21 DR. COOK:
22 A. Well, she--first thing I remember is Dr.
23 Williams reassuring her that her comments
24 would be protected under legislation, that she
25 expressed appreciation for Dr. Williams in

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1 that he was listening to the concerns of the
2 technologists and pathologists regarding the
3 issue surrounding the lab. So she was greatly
4 appreciative of an individual like him
5 listening to the various concerns that we had.
6 She listed off a large number of deficiencies
7 in the lab with the lack of standardization,
8 standard operating procedures, issues
9 regarding calibration of pipettes, issues
10 regarding documentation, books, internet, that
11 sort of stuff.
12 COFFEY, Q.C.:
13 Q. Now Doctor, in terms of that, were you
14 surprised by what she was saying?
15 DR. COOK:
16 A. Yeah, I must say, I was very surprised. I
17 mean, I sort of expected Dr. Banerjee to say
18 what he did, but I must say, I was overwhelmed
19 by Trish Wegrynowski's report.
20 COFFEY, Q.C.:
21 Q. And why is that?
22 DR. COOK:
23 A. Well, I didn't expect for her to identify the
24 number of deficiencies that she did. The
25 technical aspect of the lab is not an area

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1 that I frequent usually. I mean, my main
2 focus is on the medical staff. The technical
3 aspect is under the program director and
4 divisional manager. So I was a bit taken
5 aback by the number of deficiencies outlined
6 in her report.
7 COFFEY, Q.C.:
8 Q. And I take it that was in the exit interview
9 and then in the report itself?
10 DR. COOK:
11 A. Yes.
12 COFFEY, Q.C.:
13 Q. Because her report, I take it, mirrored her
14 exit interview.
15 DR. COOK:
16 A. Yes, her report mainly mirrored that.
17 COFFEY, Q.C.:
18 Q. So Doctor, a lot of the deficiencies that she
19 identified, I take it, despite the fact that
20 you would, at times, be back and forth to the
21 laboratory, you hadn't realized that those
22 sorts of deficiencies were there?
23 DR. COOK:
24 A. No, I hadn't realized that.
25 COFFEY, Q.C.:

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1 Q. Doctor, after Trish Wegrynowski then left St.
2 John's, in terms of investigations as to what-
3 -as to the reasons for test failure, to use
4 Dr. Banerjee's phraseology, was there any
5 other investigation being conducted at that
6 point as to the reasons for test failure?
7 DR. COOK:
8 A. No. We relied mainly on the two external
9 reviewers.
10 COFFEY, Q.C.:
11 Q. That would be Dr. Banerjee and Ms.
12 Wegrynowski?
13 DR. COOK:
14 A. That's correct.
15 COFFEY, Q.C.:
16 Q. And as you just pointed out, Dr. Williams had
17 told Ms. Wegrynowski that in his view, her
18 review was conducted by--was protected by
19 legislation?
20 DR. COOK:
21 A. That's correct.
22 COFFEY, Q.C.:
23 Q. So Doctor, just so the Commissioner is clear
24 then, as of the end of September 2005, to your
25 knowledge, there was not going to be any other

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1 investigation as to why these problems had
2 occurred, other than the two conducted by the
3 external reviewers, and they would remain
4 secret, as it were?
5 DR. COOK:
6 A. That's correct, wold remain protected under
7 legislation.
8 COFFEY, Q.C.:
9 Q. Protected. So protected that when you went to
10 talk to the pathologists about Dr. Banerjee's
11 report, you actually had to--you felt you had
12 to ask Dr. Williams' permission to do it?
13 DR. COOK:
14 A. Yes, that was made clear to me and I could not
15 produce copies of the report.
16 COFFEY, Q.C.:
17 Q. Were you asked for copies of the report by the
18 pathologists?
19 DR. COOK:
20 A. One pathologist did, Dr. Ejeckam requested
21 copies of the report to me and I told him that
22 I was unable to do that, if he had any
23 concerns about wanting the copies, he could
24 certainly relay that to the Vice President
25 Medical Services or if any time he wanted to

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1 look at the copies that I had, he was free to
2 do so.
3 COFFEY, Q.C.:
4 Q. Okay. Now if we could, please, Exhibit P-
5 0597? And Doctor, this is an e-mail from Dr.
6 Mullen to yourself, September 26th 2005.
7 DR. COOK:
8 A. Um-hm.
9 COFFEY, Q.C.:
10 Q. He is forwarding you results and an ER/PR
11 code. He writes, "if you have any questions,
12 please do not hesitate to call me, Brendan
13 Mullen." I take it, would this be probably
14 the first results, in terms of the retesting
15 batch?
16 DR. COOK:
17 A. I believe, yeah.
18 COFFEY, Q.C.:
19 Q. And Doctor, when you received these results,
20 what did you do with them?
21 DR. COOK:
22 A. I notified Dr. Williams that I had received
23 them.
24 COFFEY, Q.C.:
25 Q. Yes.

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1 DR. COOK:
2 A. And then wanted to speak to him on how we were
3 to handle this and how this was going to be
4 incorporated into hospital information systems
5 and how the patients were to be assessed, in
6 terms of treatment recommendations.
7 COFFEY, Q.C.:
8 Q. And what were you told?
9 DR. COOK:
10 A. He would get back to me. I believe there would
11 have--there was discussion with other
12 physicians, the surgeons, the oncologists, as
13 well as myself, regarding the formation of a
14 tumour panelling process.
15 COFFEY, Q.C.:
16 Q. So I take it, Doctor, before September 26th,
17 2005, those subject matters had not been
18 discussed, like the nitty gritty of what was
19 going to happen?
20 DR. COOK:
21 A. Not that I could recollect.
22 COFFEY, Q.C.:
23 Q. What then happened in that regard, Doctor?
24 DR. COOK:
25 A. Well, there were numerous meetings. Again,

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1 it's kind of a blur, but there were numerous
2 meetings going around to try to set up a
3 panelling process. One of the things that I
4 wanted to get approval for was the format on
5 how to report the ERs and PRs coming in from
6 Mount Sinai. So there was a meeting I had
7 with oncologists and surgeons and which I
8 presented the format of the reporting process
9 that I wanted to follow, and that got
10 approved.
11 COFFEY, Q.C.:
12 Q. And if we could, please, Exhibit P-1290?
13 Doctor, this is a letter of September 26th,
14 2005 from yourself to Dr. Williams. The
15 subject is ER and PR review. You write
16 "following the exit interviews about the
17 medical and technical consultants, one of the
18 issues identified in the IHC staining of
19 estrogen and progesterone perceptors concerns
20 adequate fixation of the specimen. It appears
21 in some cases that mastectomy specimens and
22 other breast biopsies could very well be left
23 lying overnight or over the weekend in the OR
24 without adequate formalin fixation. I would
25 strongly recommend that all mastectomies,

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1 needle localizations and lumpectomies with
2 axillary node dissection should be booked
3 first thing in the morning in the OR from
4 Monday to Friday. Ideally, these procedures
5 should not be performed on Friday afternoons.
6 Every effort should be made to ensure these
7 cases are forwarded to the lab in a timely
8 fashion. I would appreciate it if this
9 information could be forwarded to those
10 individuals responsible for OR bookings."
11 Signed, Donald Cook.
12 Now Doctor, here, there's a note up here
13 on the top right-hand side, September 26th,
14 2005, this would be. "Spoke to Shirley"?
15 DR. COOK:
16 A. That's Shirley Taylor. She's our divisional
17 manager in the OR at St. Clare's.
18 COFFEY, Q.C.:
19 Q. "Regarding possibility of scheduling breast
20 cases early in morning. Shirley states many
21 issues regarding rescheduling of the breast.
22 Follow up to my August memo."
23 DR. COOK:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. And we looked at that earlier today, your
2 August memo to the same effect.
3 DR. COOK:
4 A. Right, yes.
5 COFFEY, Q.C.:
6 Q. What then happened with respect to this issue,
7 Doctor?
8 DR. COOK:
9 A. Well, I spoke at great length with Shirley and
10 told her the issues that we had with our
11 reporting, particularly of the ER and PR, the
12 need to keep a close watch on the fixation.
13 Most of the cases for breast now were coming
14 to St. Clare's, so I said to Shirley that we
15 certainly have to make every effort, once the
16 surgery is completed, that the tissue is
17 forwarded immediately to the lab. Once there,
18 our pathologists--our technologists will then
19 notify our pathologists and which we would
20 then handle the specimen. I said if there is
21 any time that a specimen goes over--surgery
22 goes over after hours, say 6 or 7:00, the
23 pathologist on call is to be called in and
24 that individual will then handle the
25 mastectomy specimen. I said I would certainly

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1 appreciate not doing these cases on Friday
2 afternoons because there's always the
3 possibility that these cases could be missed
4 and left over the weekend, and I said I wanted
5 that to be avoided at all costs, if possible.
6 So Shirley was quite receptive. The other
7 thing is we were trying to reschedule a
8 particular surgeon who was doing breast
9 surgery on Friday afternoons but because of
10 scheduling problems with clinics and whatnot,
11 that was pretty difficult to do, but she
12 assured me that the breast surgery would take
13 place early in the afternoon and that we would
14 be notified of the specimens.
15 COFFEY, Q.C.:
16 Q. So did that matter actually get addressed?
17 DR. COOK:
18 A. Well, I think it did. I certainly noticed a
19 great improvement in the transportation of the
20 breast specimens to the pathology lab. There
21 was a great deal of attention paid to it by
22 the OR staff. So it didn't get addressed in
23 terms of a formal reply, but it got certainly
24 addressed in terms of what was happening with
25 the breast tissue.

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1 COFFEY, Q.C.:
2 Q. Okay. Exhibit P-0612, please? Thank you.
3 Doctor, I understand that these are your
4 notes?
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. It's "up to No. 4, September 30th, 2005."
9 What does that refer to? Do you know -
10 DR. COOK:
11 A. Again, must be up to the cases up to that
12 particular time, I believe.
13 COFFEY, Q.C.:
14 Q. What were -
15 DR. COOK:
16 A. Or I don't know what that means, that
17 September 30th, 2005. I can't comment on that,
18 Mr. Coffey.
19 COFFEY, Q.C.:
20 Q. And then when we look, though, this is, in
21 effect, a handwritten spreadsheet?
22 DR. COOK:
23 A. Um-hm.
24 COFFEY, Q.C.:
25 Q. The year spelled out on the first column?

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. Then you've got "hard conversion"?
5 DR. COOK:
6 A. Yeah.
7 COFFEY, Q.C.:
8 Q. In a column with a number of percentages?
9 DR. COOK:
10 A. Yeah.
11 COFFEY, Q.C.:
12 Q. "Soft conversion" a number of numbers and
13 percentages. And "Good correlation"?
14 DR. COOK:
15 A. Um-hm.
16 COFFEY, Q.C.:
17 Q. Numbers and percentages. First of all,
18 Doctor, what's a hard correlation--I'm sorry,
19 a hard conversion?
20 DR. COOK:
21 A. Well, this looks like Dr. Carter's
22 terminology. This would be probably
23 information that I got from here. A hard
24 conversion would have been, say, you're going
25 from a negative to a positive, ie, you know,

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1 from zero percent up to 15 or 20 percent.
2 Soft conversion possibly could mean that there
3 is conversion around the cutoff point of0
4 percent. Like I say, you could have something
5 going from eight percent to 12 percent or
6 something like that. I believe that's what
7 she referred to in her definitions.
8 COFFEY, Q.C.:
9 Q. So is this--this is your handwriting?
10 DR. COOK:
11 A. Yeah.
12 COFFEY, Q.C.:
13 Q. But it's her terminology?
14 DR. COOK:
15 A. Yeah, because I probably would have copied
16 this off a sheet that she had submitted to me.
17 COFFEY, Q.C.:
18 Q. So I take it by this point in time she's now
19 involved in at least doing some calculations?
20 DR. COOK:
21 A. Yes, she was always there to provide advice
22 and use as a resource person.
23 COFFEY, Q.C.:
24 Q. So in terms then, just looking at, for
25 example, in the totals, the total is 142

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1 cases?
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. Spanning the years 1999 through 2004. You
6 have hard conversions noted to be 35 cases in
7 total, 25 percent; 31 soft conversions, 22
8 percent; and then good correlation is 76 of
9 them is 53 percent?
10 DR. COOK:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. The purpose in creating this sort of a
14 spreadsheet was what?
15 DR. COOK:
16 A. Just to give an idea of the type of
17 conversions and our conversion rates over
18 those particular time period, based on a
19 relatively small number of patients. That's
20 142 out of, you know, hundreds of patients
21 that we had.
22 COFFEY, Q.C.:
23 Q. And, Doctor, why would that be relevant, you
24 know, at this stage?
25 DR. COOK:

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1 A. I'm not sure when I got it at this stage, it
2 could have been earlier, but, again, it would
3 have given us an idea of our conversion rate
4 around those years.
5 COFFEY, Q.C.:
6 Q. Doctor, up to September 30th and around that
7 time I take it if you had 142 cases retested,
8 they were not done in St. John's? They would
9 have had to have been involved, at least some
10 of them involved in Mount Sinai?
11 DR. COOK:
12 A. Now, she could have gotten that from the paper
13 records.
14 COFFEY, Q.C.:
15 Q. But to get a conversion wouldn't you have to
16 have a retest?
17 DR. COOK:
18 A. Yeah, you would. So again, I can't comment on
19 where I got those figures, but they look like
20 that's her figures.
21 COFFEY, Q.C.:
22 Q. Okay. Exhibit P-0604, please?
23 DR. COOK:
24 A. I mean, if that's at the right time, Mr.
25 Coffey. I can't guarantee the date. I mean,

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1 it could have been October 30th.
2 COFFEY, Q.C.:
3 Q. And, Doctor, this is your note?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. October the 3rd, 2005, a letter from the
8 cancer clinic, Kara to Pat, "Will draft a
9 letter to the clinicians."
10 DR. COOK:
11 A. That's correct.
12 COFFEY, Q.C.:
13 Q. That would be Kara Laing to Pat Pilgrim?
14 DR. COOK:
15 A. That's correct.
16 COMMISSIONER:
17 Q. Or and?
18 COFFEY, Q.C.:
19 Q. Pardon me?
20 COMMISSIONER:
21 Q. Is that a two or is that an and?
22 COFFEY, Q.C.:
23 Q. Oh, I apologize, Commissioner, good point. Is
24 it Kara -
25 DR. COOK:

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1 A. "Kara and".
2 COFFEY, Q.C.:
3 Q. "And" I apologize, Commissioner.
4 DR. COOK:
5 A. "And Pat."
6 COFFEY, Q.C.:
7 Q. No. 2, "Draft an addendum report."
8 DR. COOK:
9 A. Um-hm.
10 COFFEY, Q.C.:
11 Q. "That Alan and Al" -
12 DR. COOK:
13 A. That would be Dr. Felix -
14 COFFEY, Q.C.:
15 Q. To give what?
16 DR. COOK:
17 A. - and Dr. Kwan to give the okay on that.
18 COFFEY, Q.C.:
19 Q. This would be the addendum report that you had
20 drafted put into the Meditec system for the
21 retesting results?
22 DR. COOK:
23 A. That's right.
24 COFFEY, Q.C.:
25 Q. Why would you consult Alan Kwan and Al Felix

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1 about that?
2 DR. COOK:
3 A. Because they had concerns about, particularly
4 Dr. Kwan, about the original reports where the
5 ER and PRs were physically embedded on the
6 report. Some pathologists would report their
7 ERs and PRs as an addendum on the top of the
8 report, others would bury their report in the
9 microscopy. So to make it more convenient for
10 them to compare the original report as well as
11 the report from Mount Sinai, Dr. Kwan in
12 particular wanted that, the originals and the
13 reports from Mount Sinai placed in a separate
14 comment in a separate format.
15 COFFEY, Q.C.:
16 Q. Did he tell you why that was so? I take it so
17 it would be noticeable when you read it?
18 DR. COOK:
19 A. Yes, so he can actually see the original ER/PR
20 report and then compare it to the Mount Sinai
21 result.
22 COFFEY, Q.C.:
23 Q. No. 3, "Outside of St. John's send addendum
24 report to lab director, then lab director
25 would correlate original report with Mount

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1 Sinai report." Is that what that -
2 DR. COOK:
3 A. I think what I'm talking about there, sending
4 out a hard copy of the Mount Sinai report.
5 Like, if the Excel spreadsheet came in, I
6 would generate a hard copy of that and forward
7 that hard copy to the lab director. There may
8 also be times that there may be correlation
9 between certain reports we see from Mount
10 Sinai and various consultative reports also
11 received from Mount Sinai.
12 COFFEY, Q.C.:
13 Q. Exhibit P-0603, please? Doctor, these are Dr.
14 Williams' handwritten notes. But on page 2
15 apparently these relate to a meeting of
16 October 3rd, 2005. He's noted in the corner
17 of the document, "How to report. Send letter
18 to everyone, medical director of cancer
19 clinic." And there's a number of (1) overview
20 of decision, (2) results to date (3) status of
21 future results (4) long term, (5) individual
22 information, public information, living/dead."
23 DR. COOK:
24 A. Um-hm.
25 COFFEY, Q.C.:

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1 Q. And then there are a number of attendees.
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. Doctors Kwan, Felix, Hunt, Laing, Mr. Tilley,
6 yourself, Ms. Bonnell, Ms. Predham, Ms.
7 Parsons, Ms. Pilgrim and Dr. Williams.
8 DR. COOK:
9 A. Um-hm.
10 COFFEY, Q.C.:
11 Q. And there's a note here, "Regional lab
12 directors to get the reports."
13 DR. COOK:
14 A. Um-hm.
15 COFFEY, Q.C.:
16 Q. I take it that's, and it cross references what
17 we just looked at for your own note?
18 DR. COOK:
19 A. That's right.
20 COFFEY, Q.C.:
21 Q. Of that meeting. And reference "Dead
22 individuals follow up when all living done."
23 So I take it that the deceased results or
24 whether not--even for the deceased were yet
25 retested, that would be done after the living

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1 were?
2 DR. COOK:
3 A. Yes.
4 COFFEY, Q.C.:
5 Q. Addressed.
6 DR. COOK:
7 A. That was the plan, I think.
8 COFFEY, Q.C.:
9 Q. And then under "Decision" here he's got,
10 "Issue addendum here to include previous
11 reports. Dr. Cook to follow up with regional
12 lab directors."
13 DR. COOK:
14 A. Um-hm.
15 COFFEY, Q.C.:
16 Q. No. 2, "Cancer clinic draft letter to
17 physicians." That should be Ms. Pilgrim and
18 Dr. Laing. And No. 3, "Set up clearing house
19 for information of patient contact.
20 Counselling available. Heather Predham and
21 Chris Parsons." I take it they were charged
22 with doing that?
23 DR. COOK:
24 A. Yes.
25 COFFEY, Q.C.:

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1 Q. If we could, please, Exhibit P-0602? Now
2 here, Doctor, these are some more of your
3 notes. I take it these are your handwriting?
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. And reads, "October 1, 2005. Spoke to Dr.
8 Dankwa at NAP meeting. To send him pathology
9 report on St. Anthony cases." Same date,
10 "Updated NAP members on ER and PR situation."
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. So I take it you were--this was the day before
15 the matter went public? October the 2nd is
16 the Independent story, so -
17 DR. COOK:
18 A. Yes.
19 COFFEY, Q.C.:
20 Q. The Newfoundland Association of Pathology
21 members, you were telling them the situation?
22 DR. COOK:
23 A. Updating on the situation and what I found and
24 what my concerns were.
25 COFFEY, Q.C.:

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1 Q. And October 3rd, 2005, "Meeting with surgeons,
2 oncologists. Dr. Ed Hunt to discuss media
3 handling."
4 DR. COOK:
5 A. Yes.
6 COFFEY, Q.C.:
7 Q. Do you recall what that was about,
8 particularly the reference to Dr. Hunt is what
9 I'm -
10 DR. COOK:
11 A. Dr. Hunt works with the Department of Health
12 and Community Services.
13 COFFEY, Q.C.:
14 Q. Yes.
15 DR. COOK:
16 A. He's a medical consultant. Again, we're
17 trying to decide how to go public, what route
18 we would take and what we would address and so
19 that was a meeting with him and the
20 oncologists and the surgeons, I believe.
21 Again, I can't remember the exact specifics of
22 that meeting.
23 COFFEY, Q.C.:
24 Q. Well, Doctor, in fact, when we look, if you
25 could go back, please, to Exhibit P-0603?

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1 DR. COOK:
2 A. Okay.
3 COFFEY, Q.C.:
4 Q. This is the same day, October 3rd. And I'm
5 going to -
6 DR. COOK:
7 A. Okay.
8 COFFEY, Q.C.:
9 Q. The third name there is Dr. Hunt's.
10 DR. COOK:
11 A. Right. That would be that.
12 COFFEY, Q.C.:
13 Q. So in this larger meeting and it certainly
14 does involve oncologists and surgeons, this
15 issue of--if we could go back then to Exhibit
16 P-0602, please? Yes, you've noted here,
17 Doctor, Ed Hunt is to discuss media handling?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. And up to that point had, to your knowledge,
22 the Department of Health and certainly Dr.
23 Hunt been involved in the media and how they'd
24 be handled?
25 DR. COOK:

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1 A. Well, as I said, they would have been looking
2 towards public disclosure at an earlier date,
3 so I would certainly think and if I remember
4 correctly, that Dr. Hunt would have been sort
5 of pushing for that.
6 COFFEY, Q.C.:
7 Q. By then, this is the day after, October 3rd is
8 the day after the Independent story, so by the
9 day October 3rd, by the day that happened,
10 this was public knowledge.
11 DR. COOK:
12 A. Yes, okay.
13 COFFEY, Q.C.:
14 Q. So and if you can't remember any more, then
15 you can't. October 4, 2005, "Confirm--
16 conference call," I'm sorry, "of CEOs and
17 medical directors on issues surrounding ER and
18 issuing of addendum report."
19 DR. COOK:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. I take it that was to talk to the people in
23 the other health authorities about the
24 practicalities of -
25 DR. COOK:

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1 A. Right.
2 COFFEY, Q.C.:
3 Q. - the Mount Sinai results and how they'd be
4 entered in patients' charts?
5 DR. COOK:
6 A. Yeah.
7 COFFEY, Q.C.:
8 Q. And then "Letter to be drafted by cancer
9 clinic."
10 DR. COOK:
11 A. Um-hm.
12 COFFEY, Q.C.:
13 Q. Which I think we've seen a reference to in
14 your notes?
15 DR. COOK:
16 A. Yeah.
17 COFFEY, Q.C.:
18 Q. Elsewhere, October 3rd, the bottom of the
19 page, 2005, "Spoke to Maurice Dalton regarding
20 receipt of Grand Falls cases and 17 cases
21 submitted to St. John's."
22 DR. COOK:
23 A. Yeah.
24 COFFEY, Q.C.:
25 Q. "In June, 2005."

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1 DR. COOK:
2 A. Yeah.
3 COFFEY, Q.C.:
4 Q. Do you recall what that was about?
5 DR. COOK:
6 A. Again, more conversation with Maurice Dalton.
7 I mean, Maurice had great concerns over the
8 role of the pathologists in the ER/PR issue,
9 the role of interpretation, you know, and how
10 it was going to affect the pathologists, the
11 patients, the overall imagine of pathology in
12 Newfoundland. Those were various concerns
13 that Maurice would express with me in
14 conversations, and at times the conversations
15 were quite lengthy, anywhere from half an hour
16 to an hour sometimes over the phone with his
17 concerns about the state of pathology in
18 Newfoundland.
19 COFFEY, Q.C.:
20 Q. I'm going to suggest to you, Doctor, would it
21 be unfair for me to suggest that Dr. Dalton,
22 when you spoke to him at times about this
23 issue, was, the word that comes to mind is
24 "distraught", but I don't want to use that if
25 it's too strong. Was he really concerned

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1 about this, upset about it?
2 DR. COOK:
3 A. Oh, he was absolutely concerned. It struck at
4 the heart of his well being. He was
5 absolutely, you know, overwhelmed by all of
6 this. I could tell there was a lot of stress
7 over the phone. You know, Maurice, this had
8 hit him really hard.
9 COFFEY, Q.C.:
10 Q. And finally here, Doctor, October 4th, 2005,
11 you've noted, "Spoke to Alan Kwan regarding
12 the format of the draft report." I take it
13 that's the draft of an addendum?
14 DR. COOK:
15 A. Yes.
16 COFFEY, Q.C.:
17 Q. As to how it should be entered?
18 DR. COOK:
19 A. Yes.
20 COFFEY, Q.C.:
21 Q. Okay. If we could, please, Exhibit P-0610?
22 This is a canned text dictionary at the top of
23 the page here. And then I take it, Doctor,
24 this is a draft of the sort of text that you'd
25 use?

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. Or you were proposing to use, anyway, in terms
5 of entering the Mount Sinai results into the
6 Meditec record of each patient?
7 DR. COOK:
8 A. Right.
9 COFFEY, Q.C.:
10 Q. Okay. And below this in your handwriting, I
11 take it this is your handwriting?
12 DR. COOK:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. You've noted, "Spoke to Alan Kwan October 4,
16 2005. Spoke to Al Felix re October 5, 2005."
17 DR. COOK:
18 A. Um-hm.
19 COFFEY, Q.C.:
20 Q. That's regarding this whole issue?
21 DR. COOK:
22 A. Um-hm.
23 COFFEY, Q.C.:
24 Q. Did they both finally agree with the approach
25 you took?

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1 DR. COOK:
2 A. Yes, they did.
3 COFFEY, Q.C.:
4 Q. And there's a note here, "Highlight the
5 specimen. This specimen has been retested at
6 Mount Sinai for immunohistochemical status
7 using block," and block would be filled in.
8 The highlight, I take it, the notion was that
9 somehow that would be highlighted in the text?
10 DR. COOK:
11 A. That's correct.
12 COFFEY, Q.C.:
13 Q. Can, in Meditec, things be bolded, do you
14 know?
15 DR. COOK:
16 A. I believe so, yeah.
17 COFFEY, Q.C.:
18 Q. And here you've noted, "Received direction to
19 issue Mount Sinai report in hospital
20 information system at meeting of October 3rd,
21 2005. People at the meeting included the CEO,
22 George Tilley, Ed Hunt, Pat Pilgrim, Susan
23 Bonnell, Kara Laing, Al Felix, Alan Kwan, Don
24 Cook, Bob Williams, Heather Predham and Nancy
25 Parsons. And you've noted here "Letter to be

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1 generated by cancer clinic is to be sent out
2 to surgeons." I take it that's this letter to
3 let the surgeons know, kind of a form letter?
4 DR. COOK:
5 A. I believe.
6 COFFEY, Q.C.:
7 Q. In the meantime, Doctor, why would you take
8 the trouble to note in a formal way who was
9 telling you or who had approved of you doing
10 it in this manner?
11 DR. COOK:
12 A. In regards to the format?
13 COFFEY, Q.C.:
14 Q. Yes.
15 DR. COOK:
16 A. Of the letter, of the -
17 COFFEY, Q.C.:
18 Q. Of the addendum.
19 DR. COOK:
20 A. Well, this was something new that was being
21 happening. Normally what happens whenever we
22 get consults from the outside and we issue
23 addendum reports, this would normally be
24 issued by the attending pathologist. In this
25 particular case we were going outside the

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1 normal practice. This is an unusual
2 situation, a unique situation and I just want
3 to make sure that the CEO and the vice
4 president of medical services knew what I was
5 doing and getting approval from that.
6 COFFEY, Q.C.:
7 Q. Okay. And to keep a record of the fact that
8 that had been done?
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. Exhibit P-0607, please? Are these your notes,
13 Doctor?
14 DR. COOK:
15 A. Yeah.
16 COFFEY, Q.C.:
17 Q. Okay. It's an update from Terry Gulliver,
18 October 3rd, 2005?
19 DR. COOK:
20 A. Um-hm.
21 COFFEY, Q.C.:
22 Q. And I take it this is--it refers to
23 Gander/Carbonear, Carbonear/Grand Falls, Grand
24 Falls/Corner Brook and the Health Care
25 Corporation. And this is an update, I take

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1 it, as to the status in respect of those
2 geographic locations, particular years and
3 where you were with the cases at the time.
4 DR. COOK:
5 A. That's correct.
6 COFFEY, Q.C.:
7 Q. So, when we look down through that, I take it
8 as of early October there was still quite a
9 number of cases you expected from outside St.
10 John's?
11 DR. COOK:
12 A. Yes.
13 COFFEY, Q.C.:
14 Q. For example here, in Corner Brook, there's a
15 note here, "Terry sent off whole list of
16 referrals, end of August, still no cases,
17 however they are working on them".
18 DR. COOK:
19 A. Yes, so he would have been communicating with
20 Corner Brook for cases.
21 COFFEY, Q.C.:
22 Q. And for example, "Grand Falls, 2002 received
23 17 cases, have not been sent off" and then
24 there's a note above that for Grand Falls,
25 "came in September 30, 2005, 87 cases in total

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1 who require screening from Dr. Cook to be sent
2 off".
3 DR. COOK:
4 A. Um-hm.
5 COFFEY, Q.C.:
6 Q. So, as of the beginning of October 2005, there
7 was still a fair amount of, a number of cases
8 to come and to be packaged up and sent to
9 Mount Sinai?
10 DR. COOK:
11 A. Yeah.
12 COFFEY, Q.C.:
13 Q. Exhibit P-0614, please. This is an e-mail,
14 Doctor, from Heather Predham to a number of
15 individuals including yourself from October
16 4th, 2005. She begins by saying, "I just
17 wanted to update you on the database" and part
18 way through it she says, "in the results list
19 from yesterday, and there were several
20 patients who had more than one sample sent"
21 and she says, in bold print, "Dr. Cook, can
22 you let me know if you want the separate
23 specimens tracked or can I just track the
24 individual patients"? Do you recall who you
25 replied to that?

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1 DR. COOK:
2 A. We tracked the individual patients. Part of
3 the problem with this process is it became
4 quite complex. It wouldn't be unusual for a
5 patient to have as many as three, four, up to
6 five different operative procedures on the
7 same breast. Sometimes they were performed by
8 the same surgeon in the same institution or
9 sometimes they would be performed by the same
10 surgeon in different institutions or different
11 surgeons in different institutions. So,
12 trying to keep track of all this was a
13 monumental task indeed. And it wasn't unusual
14 to have as many as one or two receptors
15 ordered on different specimens at different
16 times on the same patient. So, the best way--
17 I probably would have advised Heather to track
18 the individual patient and then we would try
19 to track down how many specimens would be
20 aligned with the patient.
21 COFFEY, Q.C.:
22 Q. Exhibit P-1295, please. Now, Doctor, this is
23 a letter from Terry Gulliver, October 4, 2005
24 to Dr. Fontaine. It's copied to yourself and
25 Dr. Williams and he says, "I'm writing with

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1 respect to your letter of September 21st, 2005
2 concerning recent problems experienced with
3 IHC staining, specifically regarding the
4 estrogren and progesterone receptors". And he
5 continues, "Dr. Cook, Dr. Williams and myself
6 have received a preliminary assessment at a
7 debriefing session with both of these
8 consultants. Their recommendations would be
9 all encompassing. And currently Dr. Cook and
10 myself are putting together a strategy to deal
11 with the issues they referenced. The
12 recommendations that we will be proposing will
13 encompass the issues that are outlined in your
14 letter. I'm sure Dr. Cook will keep you
15 apprised of the progress that is made in
16 addressing these concerns".
17 So, Doctor, I raise this not only to show
18 perhaps that Dr. Fontaine was responded to by
19 Mr. Gulliver, but how much were people like
20 Dan Fontaine as the site chief kept in the
21 loop then in the fall of 2005 as to what was
22 going on, in response to the external reviews?
23 DR. COOK:
24 A. The external reviews, I mean, I would keep, I
25 was in contact with Dan at least once, twice a

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1 week on various issues and trying to keep him
2 up to date as possible with what was happening
3 with the ER/PR situation; what was happening
4 with the media; Dan's perception of public
5 opinion. And also I looked to Dan for some
6 advice and guidance on this issue as well.
7 So, certainly did my best to try to keep Dan
8 in the loop as much as possible. Usually it
9 was on a one-to-one basis, we'd get together
10 and meet at his office at the General Hospital
11 to discuss the situation.
12 COFFEY, Q.C.:
13 Q. And Exhibit P-0621, please. Doctor, the
14 source of this document is yourself and -
15 DR. COOK:
16 A. No, I think this would be Mr. Gulliver.
17 COFFEY, Q.C.:
18 Q. Actually, well -
19 DR. COOK:
20 A. From my file, but the source of it would be
21 Mr. Gulliver.
22 COFFEY, Q.C.:
23 Q. Okay, the person who actually created it would
24 be Mr. Gulliver?
25 DR. COOK:

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1 A. Correct.
2 COFFEY, Q.C.:
3 Q. And he would have given you a copy. It's
4 entitled "ER/PR cases for retest October 4th,
5 '05" and would this then have been his advice
6 as to kind of where they were overall with the
7 numbers?
8 DR. COOK:
9 A. That would be our status at that point in
10 time.
11 COFFEY, Q.C.:
12 Q. There's a note at the bottom, he says, "we
13 expect that all cases identified should be
14 sent to Mount Sinai by early next week",
15 that's October 10th, '05.
16 DR. COOK:
17 A. Um-hm.
18 COFFEY, Q.C.:
19 Q. Exhibit P-0087, now Doctor, these are
20 handwritten notes of, or typed version of
21 handwritten notes of Dr. Williams for October
22 4th, 2005 conference call. There's one of
23 them here at the bottom here, there's a bullet
24 that says, a conference call with the other
25 regional boards. "Specific issues reviewed

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1 with DC"--that would be yourself?
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. And then there's a question of "whether we
6 should notify all patients who are being
7 retested". What was the situation at that
8 point in terms of notification of individual
9 patients about whether they were being
10 retested? It was already public two days
11 before, so.
12 DR. COOK:
13 A. Yes.
14 COFFEY, Q.C.:
15 Q. Do you recall -
16 DR. COOK:
17 A. I'm trying to remember now what went on at
18 that particular meeting.
19 COFFEY, Q.C.:
20 Q. If you're able to, fine, Doctor and if you're
21 not, Doctor, I'll just simply to have to try
22 to -
23 DR. COOK:
24 A. Yes, I just can't remember, Mr. Coffey.
25 COFFEY, Q.C.:

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1 Q. Okay, thank you. Exhibit P-0626 please. Now,
2 Doctor, these are, in the first pages is some
3 e-mails involving Susan Bonnell and Lynn
4 Barter. And Susan Bonnell sends a copy of a
5 letter that Ms. Barter of the NLMA had sent to
6 her. It's October 6th, 2005. The letter is
7 attached and it's one prepared for Dr.
8 Williams' signature. And just to let you
9 know, Ms. Barter had advised Ms. Bonnell, "now
10 posted to our website and will go to all
11 members in an e-update later today".
12 DR. COOK:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. In the text of this letter, the fourth last
16 paragraph in this third line says, "from the
17 results that we have retested thus far, we are
18 anticipating that less than 10 percent of all
19 breast cancer patients will convert from a
20 negative to a positive and may experience a
21 change or addition to their cancer therapy.
22 Patients with positive ER and PR results or
23 those who previously received hormone therapy
24 for their cancer are not impacted". Now, I
25 refer you to this Doctor because I wanted to

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1 ask you, did anyone ever consult you as to
2 what sorts of figures you were anticipating?
3 DR. COOK:
4 A. I remember speaking to Dr. Williams' regarding
5 this. Dr. Williams was using positivity
6 rates, I believe. He was--I think at that
7 time we were at 73 percent positivity. Bob,
8 in his mind was thinking about 83 percent.
9 So, he was just subtracting positivity rates
10 and trying to anticipate that that's where we
11 should be, ten percent or less in positivity
12 rates. Now, in terms--what's the date of that
13 letter?
14 COFFEY, Q.C.:
15 Q. Well, according to e-mail it was posted--it's
16 undated, but it was posted October 6, 2005.
17 DR. COOK:
18 A. Yes, that would have been a hard one to call
19 because we would just have gotten the results
20 and we wouldn't have been panelling the
21 patients at that particular time. And for me
22 to assess conversions, I would have to compare
23 their original results to that from Mount
24 Sinai. So, at that time, I would have had
25 very little information to guide him on, but

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1 there was pressure on Dr. Williams to put some
2 sort of number in the media. So, as best as I
3 could tell him, we were certainly thinking
4 around maybe 10 percent or so, possible
5 conversion rate. That was a realistic figure,
6 but I was sort of hesitant in going, releasing
7 those figures because we certainly didn't have
8 any farm idea of the conversion rates at that
9 particular time.
10 COFFEY, Q.C.:
11 Q. So, I take it then, Doctor, to use the
12 vernacular, to the effect--Dr. Williams, if
13 you are going to use the ten, don't quote me
14 on it, as it were in terms of from your own
15 perspective. Is that -
16 DR. COOK:
17 A. Well, I wouldn't say that. I mean, I would
18 say that the ten percent at that time, to me,
19 probably sounded reasonable.
20 COFFEY, Q.C.:
21 Q. Reasonable, and that was based, I take it -
22 DR. COOK:
23 A. I mean, I wouldn't say, you know, that Dr.
24 Williams' decision entirely, I mean, I would
25 have been looking at that and I may have had

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1 some results back from Mount Sinai, it was
2 probably correlating results I may have at
3 that time, but you know, I wouldn't say it was
4 a decision made entirely by himself.
5 COFFEY, Q.C.:
6 Q. Okay. So, you may have had some input into it
7 and you understood his rationale, in terms of
8 his basis he was using, but up to that point
9 in time, hard data, as it were for you from
10 your own perspective, you wouldn't have been
11 able to point to.
12 DR. COOK:
13 A. No, we were still expecting hundreds of cases
14 to come in. So, that was our best shot, is
15 what we were figuring at that time would be
16 the impact.
17 COFFEY, Q.C.:
18 Q. Exhibit P-1298 please. Doctor, this is two e-
19 mails of October 11th, 2005 in exchange
20 between yourself--well, the first of them is
21 the one between Dr. Mullen and yourself and
22 there's one below that, October 9th from
23 yourself to Dr. Mullen. It's about a
24 particular case and you raised a question
25 about would I take--in your October 9th e-mail

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1 you thought it was perhaps an inconsistency in
2 the results for a particular patient, with Dr.
3 Mullen, asking to clarify it. And he came
4 back with his response on the 11th of October,
5 see that?
6 DR. COOK:
7 A. Right.
8 COFFEY, Q.C.:
9 Q. And you then forwarded yours and his, your e-
10 mail and his response onto Dr. Williams.
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. I take it then, Doctor, that when the
15 spreadsheets came back or as they came back
16 from Mount Sinai, you were examining them and
17 looking at whether or not thee were any
18 earlier results or pre-existing results for
19 the same patients and examining them for
20 consistency. The first e-mail indicates that
21 you've actually sat apparently and -
22 DR. COOK:
23 A. What was happening was this particular lady,
24 if I remember her correctly, she may have been
25 sent up as a consultation, may have been a

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1 request -
2 COFFEY, Q.C.:
3 Q. Yes, you've noted that, yes.
4 DR. COOK:
5 A. - from our oncologist for an urgent result.
6 So, I would have entered her into the system.
7 She still would have had a block--so, we would
8 have sent up a separate block for the
9 consultation. She still would have had a
10 block in the review process. So, when that
11 got retested in the review process, it would
12 have come to my attention that there had been
13 a previous result in on the system and that's
14 where I would have picked that up.
15 COMMISSIONER:
16 Q. I just want to make sure I understand what
17 you're saying, is if--during the normal
18 process for the retest, a block from this lady
19 would have gone to Mount Sinai to be retested.
20 DR. COOK:
21 A. Um-hm.
22 COMMISSIONER:
23 Q. And in the interim an oncologist said to you,
24 I want an urgent result on this person. So,
25 you would have pulled another block for

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1 consultation.
2 DR. COOK:
3 A. That's correct, Commissioner.
4 COMMISSIONER:
5 Q. And then you have compared the results of the
6 two blocks when they came back.
7 DR. COOK:
8 A. Yes. What I was thinking at the time, I was
9 thinking if you were taking the same block
10 from the same tumour subjected it to the same
11 fixation, subjected to the same processing,
12 you would assume that you would get relatively
13 the same result. Now, what was happening when
14 I was sending cases up to Mount Sinai, they
15 were shorthanded because of their vacations
16 and whatnot. So, they were having, from what
17 I understood, trouble accessioning the blocks
18 and registrating the blocks. So, when a
19 request came into me for an urgent case or a
20 consultation, it was much easier for us to
21 pull another block and forward it to Mount
22 Sinai for testing in the consultation route
23 and that would only take us five to six days
24 to get a result.
25 COFFEY, Q.C.:

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1 Q. I take it that otherwise if you wanted Mount
2 Sinai to treat a particular case as an urgent
3 case, you'd have to tell them, you go
4 searching in that group of blocks, you got it
5 there somewhere, identify that patient, pull
6 the block out that they've already got.
7 DR. COOK:
8 A. Yeah.
9 COFFEY, Q.C.:
10 Q. And have it done, so it was easier just for
11 you to pull a block.
12 DR. COOK:
13 A. It was much easier for me to do it whereas for
14 them, they hadn't registered it at that point
15 in time.
16 COFFEY, Q.C.:
17 Q. Now, Doctor, the idea here that there are two
18 different results for two different blocks, 2E
19 and 2F.
20 DR. COOK:
21 A. Um-hm.
22 COFFEY, Q.C.:
23 Q. And bearing in mind Dr. Mullen's explanation
24 in his e-mail of October 11th.
25 DR. COOK:

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1 A. Um-hm.
2 COFFEY, Q.C.:
3 Q. What was your reaction to that? What did you
4 think of it?
5 DR. COOK:
6 A. Well, to tell you the truth, I couldn't see
7 how there'd be such a difference in the
8 fixation and processing on the same lesion. I
9 mean, you got the same breast lesion, subject
10 to the same type of fixation, be it poor or
11 bad, I couldn't really see, appreciate how you
12 would get that much difference of an ER 1 to 5
13 percent up to and ER of 20 percent. I mean
14 that, to me, is a significant difference. I
15 would expect a difference of about 5, 10
16 percent, but we're looking at a about 15
17 percent there. I was a bit surprised at that
18 result and I had a bit of trouble accepting
19 his explanation for that.
20 COFFEY, Q.C.:
21 Q. Did you ever inquire any further into it?
22 DR. COOK:
23 A. No, I didn't.
24 COFFEY, Q.C.:
25 Q. The idea that a particular slide--points out

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1 there, "poorly fixed, processed in the centre,
2 large areas poorly fixed, processed in the
3 centre. ER and PR positive cells present at
4 the periphery".
5 DR. COOK:
6 A. Um-hm.
7 COFFEY, Q.C.:
8 Q. And then, in fact, from his--well, he explains
9 here, the slide appears, the other slide
10 appears better fixed and processed with ER and
11 PR cells present throughout the slide.
12 DR. COOK:
13 A. Um-hm.
14 COFFEY, Q.C.:
15 Q. Although, again, a majority at the periphery.
16 DR. COOK:
17 A. Um-hm.
18 COFFEY, Q.C.:
19 Q. Would that be possible from two different
20 blocks, that you'd get a problem, a particular
21 problem in the centre of a slide, being one
22 slide being poorly fixed and processed?
23 DR. COOK:
24 A. It's possible. But again, you would think,
25 again, depending on--you have to look at the

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1 size of the lesion, why you would get that big
2 a difference in variability from block to
3 block.
4 COFFEY, Q.C.:
5 Q. I take it that different blocks are taken from
6 different parts of the breast in the sense of,
7 you know, physically one's--it may be next to
8 the other, it may not, I don't know.
9 DR. COOK:
10 A. Um-hm.
11 COFFEY, Q.C.:
12 Q. But you'd have one and then another?
13 DR. COOK:
14 A. Yeah. And I -
15 COFFEY, Q.C.:
16 Q. Just on that point, if I could, Doctor, a
17 block like 2E and 2F, okay, would that mean
18 that that tissue is taken 2E and 2F were
19 adjacent to each other in the patient?
20 DR. COOK:
21 A. That's correct, yeah, that's what you would
22 assume.
23 COFFEY, Q.C.:
24 Q. You would assume? Like, they would actually
25 be right next to each other?

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1 DR. COOK:
2 A. Um-hm.
3 COFFEY, Q.C.:
4 Q. And is your view that the tissue in that
5 context should be fixed in the same manner in
6 both blocks?
7 DR. COOK:
8 A. If you got peripheral staining in one block,
9 one is adjacent to the other, you would have
10 the same type of peripheral staining in the
11 other, you know, if they are side by side,
12 right, in terms of fixation.
13 COFFEY, Q.C.:
14 Q. And that, though, I take it, Doctor, assumes
15 that fixation has equally occurred, doesn't
16 it?
17 DR. COOK:
18 A. It would make that assumption.
19 COFFEY, Q.C.:
20 Q. And in this context is that really a fair
21 assumption?
22 DR. COOK:
23 A. Well, now, you got to look at the peripheral
24 aspect of the tumour, okay.
25 COFFEY, Q.C.:

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1 Q. Yes.
2 DR. COOK:
3 A. I mean, if you got a slide of tissue there and
4 if you're taking the tissue side by side,
5 normally you would take the peripheral aspect
6 of the tissue adjacent to the peripheral
7 aspect of the other block. You know what I'm
8 saying?
9 COFFEY, Q.C.:
10 Q. Normally you would, but in this particular
11 case you don't know whether that happened or
12 not, do you?
13 DR. COOK:
14 A. Well, not for sure. But, I mean, you would--
15 that's, you know, what I would do and what
16 most pathologists would do.
17 COMMISSIONER:
18 Q. Now, you'd better run that past me again, Dr.
19 Cook, I'm not sure that I understood the point
20 you were making, the latter point. Normally,
21 you're saying, that these two--because E is
22 next to F, one assumes that, in fact, the
23 slices are adjacent, come from adjacent pieces
24 of the lesion?
25 DR. COOK:

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1 A. One assumes, and that they would include both
2 normal and tumorous tissue, the edge of the
3 tumour.
4 COMMISSIONER:
5 Q. And you're also assuming that in terms of the
6 fixation process they would have gone through
7 the same, shall we say, quality of fixation?
8 DR. COOK:
9 A. Yes, be it good or bad, Commissioner.
10 COMMISSIONER:
11 Q. Okay.
12 COFFEY, Q.C.:
13 Q. If we could on that, isn't one of the
14 characteristics of poor fixation at times
15 uneven fixation throughout the tumour?
16 DR. COOK:
17 A. If you got something there in the centre of
18 the tumour, that would be an uneven fixation
19 compared to what's at the peripheral aspect of
20 the tumour.
21 COFFEY, Q.C.:
22 Q. Exhibit P-0634? Doctor, this is a fax from
23 transmission cover sheet from a fax from
24 yourself, I'm sorry, it's from Dr. Williams to
25 Dr. Carter, October 12, 2005. But he refers

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1 to you, he says, "Dr. Carter, Dr. Cook has
2 just informed me that you have agreed to sit
3 on this panel."
4 DR. COOK:
5 A. Um-hm.
6 COFFEY, Q.C.:
7 Q. "Don will be on it in an ex officio capacity
8 to ensure that all the information is
9 available from the lab medicine program.
10 You'll be there as an expert in the area of
11 breast pathology and help with the
12 deliberations of the panel. I want to thank
13 you for this." Now, this panel, I take it this
14 is the tumour panel?
15 DR. COOK:
16 A. That's correct.
17 COFFEY, Q.C.:
18 Q. What was your role in it, Doctor?
19 DR. COOK:
20 A. To provide the reports from Mount Sinai to be
21 fed into this panel and to deal with any
22 issues concerning the blocks. If there was an
23 issue where we needed another tissue block to
24 be sent up, that would be sent up. If there
25 was an area of discrepancy noted on the

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1 original pathology report with an area of
2 discrepancy noted from Mount Sinai, we would
3 investigate that and go back and bring it back
4 to the panel.
5 COFFEY, Q.C.:
6 Q. Okay. Did your role ever change while on the
7 panel? I'm not suggesting it did, I'm just
8 asking because the panel meetings started, and
9 they continued, I gather, for up to six months
10 or more.
11 DR. COOK:
12 A. Um-hm.
13 COFFEY, Q.C.:
14 Q. So did your role or participation, the nature
15 of your participation ever change?
16 DR. COOK:
17 A. It was pretty much the same.
18 COFFEY, Q.C.:
19 Q. Okay. I take it the treatment recommendations
20 were left to the oncologists and the surgeons?
21 DR. COOK:
22 A. And the surgeons, yeah.
23 COFFEY, Q.C.:
24 Q. Exhibit P-0637, please? Now, Doctor, this is
25 a letter of October 13th, 2005 to Dr. Ejeckam

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1 from yourself.
2 DR. COOK:
3 A. Um-hm.
4 COFFEY, Q.C.:
5 Q. It's copied to Dan Fontaine, Mr. Gulliver and
6 Dr. Williams. And you write, "As discussed, I
7 appreciate your continuing role in overseeing
8 the immunoperoxidase service. As you know, we
9 are in the process of developing a specialized
10 service with technologists solely dedicated to
11 the IHC technique. As agreed, you will
12 oversee all aspects of the IHC"--I'm sorry, it
13 should be "IP", immunoperoxidase "operation
14 and have direct supervision over the
15 technologists involved in the service. You
16 will also provide direction to all
17 pathologists involved in immunoperoxidase
18 interpretation. In areas where we hope to
19 develop subspecialized service there will
20 obviously be consultation between you and the
21 appropriate pathologist on immunoperoxidase
22 staining. If you feel there is any deviation
23 from this, you should report this immediately
24 to both the clinical chief and the vice
25 president. Once again, I thank you for your

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1 important contribution, guidance, and
2 expertise." Now, Doctor, this letter to Dr.
3 Ejeckam, how did this come about or why did it
4 come about?
5 DR. COOK:
6 A. This occurred in discussion with Dr. Ejeckam
7 with concerns that we were seeing problems
8 with the management structure of the
9 organization who was actually overseeing who
10 and who was actually providing direction to
11 who. So there were, again, a number of
12 conversations between myself and Dr. Williams
13 and between myself and Dr. Ejeckam on the need
14 to have more tightening up of the management
15 structure and getting, I guess, more control
16 and authority particularly to Dr. Ejeckam over
17 the IHC.
18 COFFEY, Q.C.:
19 Q. And did he accept that role?
20 DR. COOK:
21 A. He did.
22 COFFEY, Q.C.:
23 Q. And in a practical way what, if any,
24 difference did it make?
25 DR. COOK:

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1 A. Well, he gave him a greater authority over the
2 technologists and authority for direction.
3 COFFEY, Q.C.:
4 Q. And did you ever hear any concerns, you ever
5 hear of any deviations from this?
6 DR. COOK:
7 A. I haven't heard.
8 COFFEY, Q.C.:
9 Q. Were the technologists consulted on this?
10 DR. COOK:
11 A. Not from me. They may have been from Dr.
12 Williams, but not from me. Now, I would have
13 had some discussions with Mr. Gulliver
14 outlining the need for greater medical control
15 which I've had with him in the past, and as I
16 told you, he wasn't too receptive to that, so.
17 But discussions concerning this concerning
18 ourselves and the VP medical services.
19 COFFEY, Q.C.:
20 Q. Exhibit P-0351, please? Doctor, this is a
21 review of immunohistochemistry lab, internal
22 hospital sites, prepared for Dr. Williams by
23 yourself and Mr. Gulliver, October 13th, 2005,
24 it's dated. Doctor, how did this report come
25 about, what was its purpose?

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1 DR. COOK:
2 A. This was requested by Dr. Williams to--and
3 this was following the external reviews of Dr.
4 Banerjee and Trish Wegrynowski to prepare a
5 report to identify what we need in the
6 immunohistochemistry lab and to cost it and to
7 forward the total cost of human and financial
8 resources needed to reorganize the IHC and
9 submit that to Dr. Williams.
10 COFFEY, Q.C.:
11 Q. Were there any disagreements between yourself
12 and Mr. Gulliver about the contents of the
13 report?
14 DR. COOK:
15 A. Basically we agreed with it. I was worried
16 about a word of a recommendation used by Dr.
17 Ejeckam, I believe, in--because most of the
18 report was prepared by Mr. Gulliver, I would
19 have added information on the role of
20 subspecialization and pathologists.
21 COFFEY, Q.C.:
22 Q. And having done so, you were happy then to
23 sign the report?
24 DR. COOK:
25 A. That's correct.

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1 COFFEY, Q.C.:
2 Q. Did you get any feedback on it?
3 DR. COOK:
4 A. From Dr. Williams?
5 COFFEY, Q.C.:
6 Q. Yes.
7 DR. COOK:
8 A. We did get a letter from him in November
9 stating that we were to proceed with that and
10 that assume that the monies had been approved.
11 COFFEY, Q.C.:
12 Q. Exhibit P-0638, please?
13 COMMISSIONER:
14 Q. Mr. Coffey, when you can find a convenient
15 spot, we'll break for the day.
16 COFFEY, Q.C.:
17 Q. Thank you, Commissioner. Doctor, this is a
18 memo of October 13th, 2005 to Mr. Dyer, Mr.
19 Gulliver and Dr. Williams, it's from yourself.
20 ERs and PRs is the subject. "As originally
21 stated in my memo (dated September 6th, 2005)
22 to the laboratory directors throughout the
23 province, it was our intent to retest all
24 cases involving the Ventana system from April
25 1, '04 to August 9th, 05." And you go on to

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1 to refer to "Considering the issues that Mount
2 Sinai is having concerning capacity and
3 turnaround times of ER and PR reports, I
4 believe we should concentrate our efforts on
5 all negative ERs performed by the Ventana for
6 the time being. In speaking with Dr. Laing,
7 one of our medical oncologists, she agrees
8 with this assessment. For now we will forward
9 only negative ER cases from '04 and '05
10 Ventana years. In regards to the remaining
11 cases, we will send these at a later date when
12 capacity levels at Mount Sinai permit." And
13 you referred to that earlier today, I take it,
14 that that last part of it never did happen?
15 DR. COOK:
16 A. That's right.
17 COFFEY, Q.C.:
18 Q. Okay. If we could, just before we conclude
19 for the day, Commissioner, if we could bring
20 up, please, Exhibit P-0047? Now, Doctor, this
21 is Trish Wegrynowski's report dated November
22 9th, 2005. You've referred earlier to the
23 debriefing of her.
24 DR. COOK:
25 A. Um-hm.

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1 COFFEY, Q.C.:
2 Q. Back in September. When you were--you would
3 have received a copy of her report in
4 November?
5 DR. COOK:
6 A. Yes.
7 COFFEY, Q.C.:
8 Q. 2005. Did you review it at the time?
9 DR. COOK:
10 A. Yes.
11 COFFEY, Q.C.:
12 Q. And you had the reaction, I take it,
13 consistent with your reaction at the
14 debriefing?
15 DR. COOK:
16 A. Yes.
17 COFFEY, Q.C.:
18 Q. Which is surprise?
19 DR. COOK:
20 A. Yes.
21 COFFEY, Q.C.:
22 Q. Did you take any issue with what was in her
23 report, do you recall?
24 DR. COOK:
25 A. No, I can't recall taking any particular issue

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1 with it.
2 COFFEY, Q.C.:
3 Q. If we could then, Commissioner, Monday?
4 COMMISSIONER:
5 Q. Mr. Coffey, do you want to give me some
6 estimate of the amount of time you'll require
7 with this witness on Monday, since we have
8 other witnesses scheduled?
9 COFFEY, Q.C.:
10 Q. By the break time, by the break.
11 COMMISSIONER:
12 Q. By break?
13 COFFEY, Q.C.:
14 Q. By break time, yeah.
15 COMMISSIONER:
16 Q. Mr. Pritchard, now that you're on your feet,
17 would you want to let me know how long you
18 think you might be with Dr. Cook?
19 MR. PRITCHARD:
20 Q. At this point I don't anticipate any
21 questions.
22 COMMISSIONER:
23 Q. All right. Mr. Simmons?
24 MR. SIMMONS:
25 Q. Very few.

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1 COMMISSIONER:
2 Q. I know we're out of order, but why not, Ms.
3 Newbury, you can tell me?
4 MS. NEWBURY:
5 Q. Half hour, 45 minutes.
6 COMMISSIONER:
7 Q. Okay. Mr. Pritchett?
8 MR. PRITCHETT:
9 Q. I don't anticipate any questions,
10 Commissioner.
11 COMMISSIONER:
12 Q. Mr. Pike?
13 MR. PIKE:
14 Q. (Unintelligible) communications, but I can't
15 (unintelligible).
16 COMMISSIONER:
17 Q. All right. Mr. Browne, do you want to weigh
18 in? Depends on what these other people ask?
19 MR. BROWNE:
20 Q. Yes, I would see maximum (unintelligible).
21 COMMISSIONER:
22 Q. Okay. Thank you.
23 COFFEY, Q.C.:
24 Q. And, Commissioner, I understand from speaking
25 with Mr. Crosbie, he will have some questions.

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1 I didn't ask him about how long he'd be, but
2 he did, yes. So in any case -
3 COMMISSIONER:
4 Q. Well, certainly we can say that Dr. Cook, it
5 looks like we'll need you for at least a half
6 a day on Monday.
7 DR. COOK:
8 A. Yes, okay.
9 COMMISSIONER:
10 Q. Thank you, very much. 9:30 on Monday. Thank
11 you, all. Enjoy your weekend.
12 Upon conclusion.

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 4th day of July, A.D., 2008 before the
6 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 4th day of July, A.D., 2008
13 Judy Moss

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