

<p>COMMISSION OF INQUIRY ON HORMONE RECEPTOR TESTING</p> <p>BEFORE THE HONOURABLE JUSTICE CAMERON - COMMISSIONER</p> <p>October 15, 2008</p> <p>Appearances:</p> <p>Bernard Coffey, Q.C. Commission Co-counsel Sandra Chaytor, Q.C. Commission Co-counsel</p> <p>Rolf Pritchard/Jackie Brazil, Q.C. . Her Majesty in Right of NL</p> <p>Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al</p> <p>Daniel Simmons Eastern Regional Integrated Health Authority</p> <p>Chesley Crosbie, Q.C.. Members of the Breast Cancer Testing Class Action</p> <p>Mark Pike, Q.C. NL Medical Association Jennifer Newbury Canadian Cancer Society (NL Division) Blair Pritchett. Central, Western and Labrador-Grenfell Regional Integrated Health Authorities</p>	<p>THIS PAGE ONLY REVISED NOVEMBER 18, 2008</p> <p>LIST OF EXHIBITS</p> <p>EXHIBITS P-2939 THROUGH P-2944 Pg. 347</p> <p>EXHIBITS P-2948 AND P-2949 Pg. 347</p> <p>EXHIBITS P-2951 THROUGH P-2957 Pg. 347</p> <p>EXHIBIT P-2960 Pg. 347</p> <p>EXHIBITS P-2965 THROUGH P-2973 Pg. 347</p> <p>EXHIBITS P-2979 THROUGH P-2981 Pg. 347</p> <p>EXHIBITS P-2983 THROUGH P-3003 Pg. 347</p> <p>EXHIBITS P-3005 THROUGH P-3029 Pg. 347</p> <p>EXHIBITS P-3031 THROUGH P-3035 Pg. 347</p> <p>EXHIBIT P-3037 Pg. 347</p> <p>EXHIBITS P-3040 AND P-3041 Pg. 347</p> <p>EXHIBITS P-3043 THROUGH P-3048 Pg. 347</p> <p>EXHIBITS P-3052 THROUGH P-3054 Pg. 347</p> <p>EXHIBIT P-3056 Pg. 347</p> <p>EXHIBITS P-3059 THROUGH P-3073 Pg. 347</p> <p>EXHIBIT P-3075 Pg. 348</p> <p>EXHIBIT P-3078 Pg. 348</p> <p>EXHIBITS P-3370 THROUGH P-3380 Pg. 348</p> <p>EXHIBITS P-3382 THROUGH P-3385 Pg. 348</p> <p>EXHIBITS P-3387 THROUGH P-3410 Pg. 348</p> <p>EXHIBITS P-3413 THROUGH P-3415 Pg. 348</p> <p>EXHIBITS P-3417 THROUGH P-3418 Pg. 348</p> <p>EXHIBITS P-3420 THROUGH P-3462 Pg. 348</p> <p>EXHIBITS C-0264 AND C-0265 Pg. 348</p> <p>EXHIBITS C-0273 AND C-0274 Pg. 348</p> <p>EXHIBITS P-3381; P-3386; P-3411 TO P-3412; P-3416 AND P-3419 CANCELLED</p>
<p>TABLE OF CONTENTS</p> <p>MR. TERRY GULLIVER - RESUMES THE STAND</p> <p>Examination by Peter Browne, Q.C. Pgs. 4 - 72</p> <p>Examination by Jennifer Newbury Pgs. 72 - 177</p> <p>Examination by Chesley Crosbie, Q.C. Pgs. 177 - 328</p> <p>Examination by Dan Simmons Pgs. 328 - 338</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 338 - 345</p> <p>MS. HEATHER PREDHAM - SWORN</p> <p>Examination by Sandra Chaytor, Q.C. Pgs. 345 - 376</p> <p>Certificate</p>	<p style="text-align: right;">Page 4</p> <p>1 THE COMMISSIONER:</p> <p>2 Q. Please be seated. Mr. Browne.</p> <p>3 MR. TERRY GULLIVER - EXAMINATION BY PETER BROWNE, Q.C.:</p> <p>4 BROWNE, Q.C.:</p> <p>5 Q. Good morning, Mr. Gulliver. Peter Browne. I</p> <p>6 represent a number of the individual</p> <p>7 physicians who have testified before the</p> <p>8 Commission. We met previously.</p> <p>9 MR. GULLIVER:</p> <p>10 A. Good morning, Mr. Browne.</p> <p>11 BROWNE, Q.C.:</p> <p>12 Q. I just want to clarify some of your answers to</p> <p>13 Ms. Chaytor's questions over the course of</p> <p>14 your testimony, and unfortunately I have to go</p> <p>15 back to the first day, but we'll try to move</p> <p>16 forward very quickly.</p> <p>17 MR. GULLIVER:</p> <p>18 A. It seems forever ago.</p> <p>19 BROWNE, Q.C.:</p> <p>20 Q. We'll try to move as quickly as we can here.</p> <p>21 You had mentioned to Ms. Chaytor that the</p> <p>22 training - I guess, the schooling program for</p> <p>23 lab technology is a three year diploma program</p> <p>24 followed by national certification exam, and</p> <p>25 that applies across - uniformly across the</p>

Page 5

1 country, is that right?
 2 MR. GULLIVER:
 3 A. The national exam does.
 4 BROWNE, Q.C.:
 5 Q. The national exam.
 6 MR. GULLIVER:
 7 A. Training programs may differ from province to
 8 province, but you do have a national
 9 competency profile that each training program
 10 has to ensure the students follow that
 11 profile.
 12 BROWNE, Q.C.:
 13 Q. Okay. Now looking at - if you wish you could
 14 call it up, and that's Ms. Wegrynowski's first
 15 report, P-0047, but generally within that
 16 review of the lab, she mentions a number of
 17 things surrounding, I guess, the equipment and
 18 use of equipment by the technologists, and in
 19 particular the pipette calibration and
 20 accuracy, the use of, I think it's an NIST
 21 thermometer. Just dealing with those two
 22 pieces of equipment, is that something that
 23 you learn about in the program in terms of use
 24 of this equipment, and, I guess, accuracy of
 25 the equipment and so on.

Page 6

1 MR. GULLIVER:
 2 A. The pipettors, you would learn how to use a
 3 pipetter in your training program.
 4 BROWNE, Q.C.:
 5 Q. Yes.
 6 MR. GULLIVER:
 7 A. But certainly the calibration of it or - and
 8 it's not the calibration of it, it's to verify
 9 that the calibration set by the manufacturer
 10 is still at that setting, whether it's a year
 11 later or two years later.
 12 BROWNE, Q.C.:
 13 Q. Right.
 14 MR. GULLIVER:
 15 A. That's really something that's a function of
 16 the biomedical engineering department.
 17 BROWNE, Q.C.:
 18 Q. Okay.
 19 MR. GULLIVER:
 20 A. Within your organization that's now who does
 21 that for us.
 22 BROWNE, Q.C.:
 23 Q. But in terms of recognizing, I guess, when -
 24 is that already set? Does the technologist
 25 have any involvement in recognizing when that

Page 7

1 needs to be done and the bio - is it the bio
 2 engineering, did you say?
 3 MR. GULLIVER:
 4 A. Yeah.
 5 BROWNE, Q.C.:
 6 Q. When they're contacted, or is it just set
 7 times when they come in?
 8 MR. GULLIVER:
 9 A. I think the protocol is to recalibrate once a
 10 year.
 11 BROWNE, Q.C.:
 12 Q. And thermometers as well?
 13 MR. GULLIVER:
 14 A. And the thermometers is the - NIST is an
 15 instrument that verifies that your thermometer
 16 is working properly. So, you know, the case
 17 where Ms. Wegrynowski had mentioned that was
 18 in the - for example, the Ventana platform,
 19 the procedures taking place inside the
 20 instrument at a certain temperature, and the
 21 instrument automatically sets itself in a
 22 program at that temperature, and she said what
 23 Mount Sinai uses, they actually put a
 24 thermometer inside the instrument and measure
 25 to make sure that the instrument is working

Page 8

1 properly and is really at that temperature.
 2 So if it's supposed to be at 37 celsius, they
 3 put a thermometer to measure that. What the
 4 NIST is then it's another calibration to make
 5 sure the thermometer you're using to measure
 6 the instrument is actually working properly.
 7 BROWNE, Q.C.:
 8 Q. So would these sorts of things -
 9 MR. GULLIVER:
 10 A. And that's not something that you learn in the
 11 general medical lab technology program.
 12 BROWNE, Q.C.:
 13 Q. Okay, and that's what I was coming back to.
 14 These sorts of things are, like, I guess,
 15 we've heard the term troubleshooting. Is that
 16 - would that canvas that, sort of checking
 17 instrumentation and so on, would that be
 18 troubleshooting?
 19 MR. GULLIVER:
 20 A. That's not really troubleshooting. That's
 21 your preventative maintenance kind of
 22 schedules.
 23 BROWNE, Q.C.:
 24 Q. Okay. The notion of troubleshooting in the
 25 lab, is that again something that is canvassed

Page 9

1 in either the national certification
 2 examination or in the training program, the
 3 three year training program?
 4 MR. GULLIVER:
 5 A. Troubleshooting, yes, it is. It's covered
 6 off, but troubleshooting in a general sense
 7 within medical laboratory technology, i.e. it
 8 could be troubleshooting in a biochemistry
 9 environment, a pathology environment,
 10 microbiology environment, but how to
 11 troubleshoot specific instances within any
 12 certain test, that really is learning on the
 13 job.
 14 BROWNE, Q.C.:
 15 Q. But the theory, the notion that it's necessary
 16 to -
 17 MR. GULLIVER:
 18 A. The theory behind it, yes.
 19 BROWNE, Q.C.:
 20 Q. Now in terms of going back to the
 21 instrumentation, such as pipettes,
 22 thermometers, and then, I guess, add to that
 23 slides and pH meters, those sorts of pieces of
 24 equipment, in your lab or in the lab at the
 25 Health Sciences Complex, who would have been

Page 10

1 responsible for ordering that type of
 2 equipment?
 3 MR. GULLIVER:
 4 A. For ordering it?
 5 BROWNE, Q.C.:
 6 Q. Yes, selection of a particular piece of
 7 equipment?
 8 MR. GULLIVER:
 9 A. They're basic lab equipment. They'd be at the
 10 division manager's level.
 11 BROWNE, Q.C.:
 12 Q. And you had mentioned in your - you became - I
 13 guess you went into management in 1987?
 14 MR. GULLIVER:
 15 A. Yes.
 16 BROWNE, Q.C.:
 17 Q. You became the divisional manager at that
 18 point?
 19 MR. GULLIVER:
 20 A. Pathology supervisor.
 21 BROWNE, Q.C.:
 22 Q. Pathology supervisor, and I was unclear, at
 23 the point that you made that transition, there
 24 was some IHC being performed. I think you'd
 25 mentioned Dr. Wang and Dr. Chittal were doing

Page 11

1 some of it at that point?
 2 MR. GULLIVER:
 3 A. For about three or four years at that point.
 4 BROWNE, Q.C.:
 5 Q. I was unclear. Were the - we've heard various
 6 evolutions of the IHC up to now the Ventana.
 7 Were kits being used at the time you were
 8 doing IHC?
 9 MR. GULLIVER:
 10 A. No.
 11 BROWNE, Q.C.:
 12 Q. Were either Dr. Chittal or Dr. Wang doing any
 13 type of antigen retrieval?
 14 MR. GULLIVER:
 15 A. No, antigen retrieval wasn't even invented
 16 then.
 17 BROWNE, Q.C.:
 18 Q. Okay, so the antibodies that they were using
 19 didn't require antigen retrieval?
 20 MR. GULLIVER:
 21 A. No.
 22 BROWNE, Q.C.:
 23 Q. Now you had - when you became manager, was
 24 there any requirement upon you, or supervisor
 25 at that point, to assess - I think we've heard

Page 12

1 that Ms. Butler and Ms. Welsh were trained to
 2 do IHC and brought in. Did you supervise and
 3 train both of these individuals in terms of
 4 their knowledge of - I guess, test their
 5 knowledge of IHC before they went on the
 6 bench?
 7 MR. GULLIVER:
 8 A. I don't think I would say that it was just
 9 myself who trained them. I certainly helped,
 10 and, you know, passed along any material that
 11 I had. I did submit during my testimony that
 12 20 page basic theory lecture that Mary and
 13 Peggy would have done and who had a copy of
 14 it. We did have a basic theory handbook that
 15 we used that was supplied by one of the
 16 companies. We had a textbook by Sternberger
 17 that we used at the bench, and again, you
 18 know, Dr. Chittal was there and he also would
 19 have been good assistance with Mary and Peggy.
 20 BROWNE, Q.C.:
 21 Q. Uh-hm.
 22 MR. GULLIVER:
 23 A. And mostly on the troubleshooting side, you
 24 know, that would read the slides.
 25 BROWNE, Q.C.:

Page 13

1 Q. You mentioned as well, I guess, that Mr.
 2 Hewlett who testified here, he had been at and
 3 did some presentations?
 4 MR. GULLIVER:
 5 A. In 1986, we had - our professional
 6 association, we had our national week long
 7 congress being hosted in St. John's, and a
 8 part of that - and it's a combination of
 9 workshops, lectures, to cover all disciplines
 10 in laboratories. It's a combination of a
 11 trade show with the new technology, like your
 12 basic overall congress, and during that time
 13 Mr. Hewlett did a one day workshop and we used
 14 the lab at the medical school to do that.
 15 BROWNE, Q.C.:
 16 Q. And were these in IHC?
 17 MR. GULLIVER:
 18 A. It was just when IHC - again back in 1986, it
 19 would have been a one day workshop in basic
 20 theory and principles in IHC, and then talking
 21 about your PAP procedure, policies procedure.
 22 BROWNE, Q.C.:
 23 Q. You mentioned in 2001 he was back again?
 24 MR. GULLIVER:
 25 A. Again we had our national congress here again

Page 14

1 in 2001, and we're here again next year, 2009.
 2 BROWNE, Q.C.:
 3 Q. In terms of - we've heard a lot about issues
 4 surrounding fixation and so on. If
 5 technologists noted problems with fixation,
 6 would it be incumbent on them to report if
 7 they saw a regular problem with fixation
 8 coming from specimens? Would it be incumbent
 9 upon them to bring that to the attention of
 10 the manager and/or the program director at an
 11 point?
 12 MR. GULLIVER:
 13 A. They wouldn't bring it to the program
 14 director. I mean, it's operations within the
 15 pathology division.
 16 BROWNE, Q.C.:
 17 Q. Right, so presumably if there was a noticeable
 18 problem, they would bring it to the manager
 19 and the manager would, if felt -
 20 MR. GULLIVER:
 21 A. In pathology, would go to the site chief.
 22 BROWNE, Q.C.:
 23 Q. Site chief.
 24 MR. GULLIVER:
 25 A. Yeah.

Page 15

1 BROWNE, Q.C.:
 2 Q. So just going back, if the technologists noted
 3 that, would their line of communication be to
 4 the manager, though, in terms of getting
 5 something rectified?
 6 MR. GULLIVER:
 7 A. It would, yes.
 8 BROWNE, Q.C.:
 9 Q. Okay, and then presumably the manager would
 10 then, if they could not resolve it directly
 11 with pathologists, go to the site chief and/or
 12 the clinical chief to get that resolved?
 13 MR. GULLIVER:
 14 A. Yes.
 15 BROWNE, Q.C.:
 16 Q. Was there ever any point prior to 2005 issues
 17 brought to your attention, either as the
 18 manager or the program director, from
 19 technologists surrounding fixation?
 20 MR. GULLIVER:
 21 A. At the Health Sciences site, which is my home
 22 base, I don't remember any instances. At St.
 23 Clare's site, I certainly was made aware of
 24 some issues up at St. Clare's.
 25 BROWNE, Q.C.:

Page 16

1 Q. And were those followed up?
 2 MR. GULLIVER:
 3 A. Yes.
 4 BROWNE, Q.C.:
 5 Q. How were they followed up?
 6 MR. GULLIVER:
 7 A. It was pretty well just in basic discussions
 8 with the site chief at St. Clare's that there
 9 seems to be an issue at St. Clare's with
 10 specimens that were not being fixed properly
 11 for either two reasons; that the specimen
 12 initially was not left in formalin long
 13 enough, or when it was grossed, the tissue was
 14 too thick to go into the cassette and -
 15 because consequently, I was made aware - I was
 16 actually the division manager for pathology at
 17 Health Sciences/Janeway, and I worked fairly
 18 closely with John Murphy, the manager of
 19 pathology at the Grace/St. Clare's, and the
 20 issue was the amount of reprocessing that the
 21 technologists at St. Clare's had to carry out
 22 primarily because the tissue was not fixed
 23 properly from the beginning at the gross
 24 bench.
 25 THE COMMISSIONER:

Page 17

1 Q. Do you remember when that was, Mr. Gulliver?
 2 MR. GULLIVER:
 3 A. It was over a period of - a fairly lengthy
 4 period. I would say probably '98, '99, 2000,
 5 during that time frame.
 6 BROWNE, Q.C.:
 7 Q. Was there any thought given to sending a memo
 8 to - like, something like along the lines of
 9 Dr. Ejeckam from sort of the technology side
 10 saying, look, could you please pay attention
 11 to these issues?
 12 MR. GULLIVER:
 13 A. I never wrote one. It was brought to the
 14 attention - at the time, only the pathologists
 15 did the grossing. It was brought to the
 16 attention of the site chief and brought to the
 17 attention of the pathologists at St. Clare's,
 18 and other than that, that's where it went.
 19 BROWNE, Q.C.:
 20 Q. Would the notion - again this is probably with
 21 hindsight. Given the high turnovers that were
 22 occurring, I guess, at both sites, would there
 23 be some benefit to having that type of memo
 24 distributed if you're seeing things from the
 25 technologists point of view, communicated back

Page 18

1 to the pathologist side, again along the lines
 2 of Dr. Ejeckam?
 3 MR. GULLIVER:
 4 A. I know, and you mentioned the high turnover,
 5 but at St. Clare's site there really wasn't a
 6 high turnover at that time. They had a stable
 7 group of pathologists there, and it was
 8 shortly after the Grace - then the Grace
 9 closed, and pathologists from the Grace moved
 10 to St. Clare's, and obviously in hindsight,
 11 such a memo like Dr. Ejeckam did in 2003 would
 12 have been appropriate in '97/'98, but again
 13 that would have to come from the site chief or
 14 clinical chief.
 15 BROWNE, Q.C.:
 16 Q. It's not something you would see coming from
 17 the technologist side?
 18 MR. GULLIVER:
 19 A. No.
 20 BROWNE, Q.C.:
 21 Q. Just to - you mentioned you had professional
 22 experience and knowledge through CMLS which is
 23 your, I guess, professional organization,
 24 national professional organization, and you, I
 25 think, testified - I think the first day you

Page 19

1 testified, that you'd learned a lot around
 2 management and administration of laboratories.
 3 Did I understand that that was mostly talking
 4 to your colleagues and dealing with colleagues
 5 from Alberta and Ontario primarily?
 6 MR. GULLIVER:
 7 A. Not really, no, it was just a combination of
 8 multiple things. When I was elected president
 9 of the CSMLS, at the time it was CSLT,
 10 Canadian Society for Laboratory Technologists,
 11 and a part of our role of being on the Board
 12 of Directors and being in the what we call the
 13 presidential chain where I was vice president
 14 for a year, president elect, president, and
 15 past president, for example, you know, they
 16 sent me to Ottawa to do two days training in
 17 communications in dealing with media. They
 18 sent me for a week to the Banff School of
 19 Management, sort of like an executive
 20 leadership kind of training to help you with
 21 dealing with board issues and governance
 22 issues, like, those kinds of things. I mean,
 23 all of that is knowledge that you gain.
 24 Certainly, I mean it does help you back in the
 25 workplace.

Page 20

1 BROWNE, Q.C.:
 2 Q. You were obviously in most organizations in
 3 the executive stream for a number of years.
 4 So what years were you actually in that sort
 5 of -
 6 MR. GULLIVER:
 7 A. 1995, I was vice president; 1996, president
 8 elect; 1997, I was president; 1998, past
 9 president.
 10 BROWNE, Q.C.:
 11 Q. So 1995 to 1998.
 12 MR. GULLIVER:
 13 A. And before I took that leap, I had been
 14 several years on our national public relations
 15 committee, you know, where you talked about
 16 your profession. Before that, I was on our
 17 exam panels, so I've been multiple roles
 18 within the organization.
 19 BROWNE, Q.C.:
 20 Q. Okay. In sort of that environment in speaking
 21 and dealing with your colleagues at that
 22 national level, were there any occasions where
 23 you discussed or learned about how labs are
 24 set up in other parts of the country?
 25 MR. GULLIVER:

Page 21

1 A. It all depends what your definition of set up
 2 is.
 3 BROWNE, Q.C.:
 4 Q. Well, I guess, in terms of lab structure,
 5 management, and those sorts of things, the
 6 notion, say, for instance, of having a lead
 7 technologist for IHC, for example?
 8 MR. GULLIVER:
 9 A. Not - no, not that kind of detail, no.
 10 BROWNE, Q.C.:
 11 Q. What about in the area of quality control and
 12 quality assurance, again were there any sort
 13 of discussions surrounding how things were set
 14 up internally or externally within these labs?
 15 MR. GULLIVER:
 16 A. No. Most discussion would be more the big
 17 picture for the profession across the country,
 18 you know, more talking about accreditation and
 19 those licensing - those kinds of issues.
 20 BROWNE, Q.C.:
 21 Q. What about in terms of advances in the
 22 profession, say, for histology, IHC, as it was
 23 expanding because this was a period where this
 24 was expanding quite - we've heard from a
 25 number of witnesses.

Page 22

1 MR. GULLIVER:
 2 A. Those kinds of things are what you would
 3 probably see at our national congress or if
 4 you went to an international conference.
 5 BROWNE, Q.C.:
 6 Q. But nothing -
 7 MR. GULLIVER:
 8 A. Not through the professional association work,
 9 no.
 10 BROWNE, Q.C.:
 11 Q. Now you had spent a bit of time, and Ms.
 12 Chaytor spent a bit of time exploring with you
 13 the set up of the Meditech system, and I
 14 understand it was introduced initially in
 15 1987?
 16 MR. GULLIVER:
 17 A. At the Health Sciences, yes.
 18 BROWNE, Q.C.:
 19 Q. And you stated I think the first day that the
 20 technical staff were more inclined to use the
 21 system as opposed to physicians?
 22 MR. GULLIVER:
 23 A. True.
 24 BROWNE, Q.C.:
 25 Q. We had learned from one of the technologists,

Page 23

1 I think it was Ms. Butler, about her
 2 reluctance towards computers and so on. Were
 3 the technicians given - the technologists,
 4 excuse me, given any courses in introduction
 5 to computers because, I guess, they both are
 6 required to use the computer for both the DAKO
 7 system when it came in, and also the Meditech
 8 system?
 9 MR. GULLIVER:
 10 A. Well, basic computer training is something
 11 that's offered all the time through the Health
 12 Care Corporation of St. John's, even now with
 13 Eastern Health, so employees can avail of your
 14 basic computer skills. To go back to '87 when
 15 Meditech came in, I mean, it was not just the
 16 technologists, it was myself as a manager who
 17 had to learn, you know, say, computer skills,
 18 in particular the Meditech system. So we did
 19 have - I think we might have been six months
 20 or eight months where we had the test system
 21 at the work bench with all the terminals for
 22 people to learn and use before we actually
 23 went to a live - to a live date.
 24 BROWNE, Q.C.:
 25 Q. Were, I guess, individuals such as

Page 24

1 technologists who were required to use both
 2 Meditech and later on computer systems such as
 3 the DAKO, were they required as part of their
 4 job to take computer courses to expand their
 5 knowledge?
 6 MR. GULLIVER:
 7 A. Well, there is no computer course in Meditech
 8 that there are - IM & T does have a training
 9 room and they do have staff who do provide
 10 basic computer training to all new staff.
 11 BROWNE, Q.C.:
 12 Q. Okay.
 13 MR. GULLIVER:
 14 A. To go through that process. The DAKO computer
 15 that was a PCU, the person who came in and set
 16 up the initial instrument who was in St.
 17 John's, I don't know, might have been three,
 18 four, or five days, did the basic computer set
 19 up with Mary and Peggy.
 20 BROWNE, Q.C.:
 21 Q. And I presume would be available for any
 22 questions on a regular basis? Was there a
 23 hotline to DAKO?
 24 MR. GULLIVER:
 25 A. Yes, it was a toll free number.

Page 25

1 BROWNE, Q.C.:

2 Q. Now as well around the DAKO system, you had

3 mentioned that there was some - and I think

4 you clarified this yesterday, some

5 difficulties standardizing the format and the

6 content. Did I understand Dr. Khalifa back in

7 1998 introduced synoptic reporting in

8 pathology?

9 MR. GULLIVER:

10 A. I really can't answer that question. I just

11 made the statement that Dr. Khalifa's

12 reporting was pretty well standard throughout

13 the whole time that I read his reports.

14 BROWNE, Q.C.:

15 Q. And your comment about standardizing the

16 content, was that in relation to the fact that

17 pathologists reported the ER/PR in different

18 fashions, and, therefore, it was hard to sort

19 of when you're going back doing searched in

20 2005 to locate all this information, is that -

21 MR. GULLIVER:

22 A. Yes, a fair assessment. They reported in

23 different fashion and they also reported in

24 different parts of the report. Some people

25 had an addendum, some people did their

Page 26

1 interpretation under the pathological

2 interpretation. We had another one that was

3 called diagnosis. Some had it as part of

4 their tumour summary. There was also no

5 standard place on the report where you could

6 find that information.

7 BROWNE, Q.C.:

8 Q. In terms of searching for that information,

9 was that difficult? I mean, could you key the

10 word in "estrogen" or "ER", and "progesterone"

11 and "PR" and get that information back? Was

12 the Meditech set up for that?

13 MR. GULLIVER:

14 A. Yes, it is, but Meditech would come back and

15 give you that key word in any single report,

16 but when you're doing the Meditech search, it

17 also asks you "and where in the report will I

18 find that key word", will I find it under

19 diagnosis, will I find it under the - it's

20 called data section, will I find it under

21 interpretation, will I find it under addendum,

22 will I find it under tumour summary. So again

23 it just makes the - it just complicates it a

24 little bit more.

25 BROWNE, Q.C.:

Page 27

1 Q. When Meditech was set up, and I gather it was

2 integrated in 1999, all the systems, did I

3 understand that correctly from you?

4 MR. GULLIVER:

5 A. Yes, when St. John's went to one -

6 BROWNE, Q.C.:

7 Q. One system.

8 MR. GULLIVER:

9 A. - one database, pretty well one system.

10 BROWNE, Q.C.:

11 Q. Right, because, I mean, I view that sort of,

12 that issue, broader than just ER/PR. Was

13 Meditech consulted as to sort of the best use

14 and most efficient use of how items could be

15 searched within a pathology report?

16 MR. GULLIVER:

17 A. I think by that time, the people who were

18 using the system, Meditech system, at all

19 sites had a fairly good knowledge in how to

20 search the Meditech system for pathology.

21 BROWNE, Q.C.:

22 Q. My question was more designed towards was

23 Meditech brought in to look at the current

24 system, say in 1999, when all the systems were

25 being--because, I think, it was recognized

Page 28

1 that different set ups existed at the various

2 hospitals. For instance, there was different

3 dictionaries at St. Clare's than there was at

4 Health Sciences. Were they brought in and

5 sort of said, "okay, now we're going to

6 integrate. Can we look at a most efficient

7 use in making sure that this does work

8 uniformly?"

9 MR. GULLIVER:

10 A. No, they weren't brought in, but we weren't

11 upgrading the Meditech system. I mean, the

12 Meditech system, it's pretty well how you

13 decide to operate the system and there's where

14 your differences is come in in dictionaries.

15 When we did the consolidation of

16 Meditech, the consolidation wasn't really

17 taking Meditech from the Grace and St. Clare's

18 and Janeway and Health Sciences and making it

19 one. It was taking the Health Sciences

20 current Meditech system and expanding that to

21 include the Grace, St. Clare's and Janeway.

22 What we did within Lab Medicine, in all parts

23 of lab, not just pathology, we worked for

24 almost a year in looking at the standard

25 operations of Meditech at each site and how

Page 29

1 could we agree upon a standard set of
 2 dictionary or template for the city-wide
 3 computer system.
 4 For example, one of the things that we
 5 did talk about was just the basic standard
 6 report format of how a pathology report would
 7 look when it went back to a physician, and we
 8 didn't get agreement on that. That ended up
 9 St. Clare's wanted to have their own report
 10 format and the Health Sciences continued to
 11 use the one that was in existence for the ten
 12 years prior. So there's the standard
 13 operations that went on.
 14 BROWNE, Q.C.:
 15 Q. So that happened internally? Meditech or
 16 their representatives weren't sort of brought
 17 in to sort of consult with you as to the best
 18 way to approach this and to come up with a
 19 solution that would work well for all sites?
 20 Is that right? They weren't sort of consulted
 21 as to -
 22 MR. GULLIVER:
 23 A. No.
 24 BROWNE, Q.C.:
 25 Q. Whose decision would that have been, to sort

Page 30

1 of bring them in, if that was viewed as a
 2 positive thing?
 3 MR. GULLIVER:
 4 A. Well, it would have been a combination of IM &
 5 T, because the consolidation was taking place
 6 for Meditech. The lab information system was
 7 one component of Meditech, so it would have
 8 been an IM & T broader decision for the
 9 organization. But again, you know, I don't
 10 know what you would need Meditech for because
 11 we weren't changing our Meditech system at
 12 all. It was for the different groups to come
 13 to a decision on how are you going to use and
 14 operate Meditech.
 15 BROWNE, Q.C.:
 16 Q. So from your -
 17 MR. GULLIVER:
 18 A. Within existing mainframe, the existing that
 19 was already there. The dictionaries are all
 20 hard coded. It's the test names you put in
 21 there and how you want to use them that you
 22 have to agree about.
 23 BROWNE, Q.C.:
 24 Q. So what I understand is you're saying, from
 25 your perspective, all it would require is a

Page 31

1 data input? It would not require their
 2 expertise to sort of -
 3 MR. GULLIVER:
 4 A. Not, no.
 5 BROWNE, Q.C.:
 6 Q. Registrar, P-1889, please? Mr. Gulliver, this
 7 exhibit was shown to you by Ms. Chaytor, and
 8 it's the letter, and I think you said you
 9 don't recall receiving this letter from Dr.
 10 Khalifa in 1997. I just want to go over a
 11 couple of comments that Dr. Khalifa made here
 12 and just ask you for your feedback. The third
 13 line here says--this is, again, you're quite
 14 familiar with this letter. You've seen it
 15 previously. It mentions, Dr. Khalifa mentions
 16 "you knew this" and this is referring now to
 17 the ER/PR kit which had been consumed the
 18 previous week. "You knew this and you were
 19 trying to use a detection system in
 20 combination with an old primary antibody that
 21 the lab had for some time. This combination
 22 did not work," and then he says he called you,
 23 but the two points I wanted to sort of draw
 24 your attention to is one, "new detection
 25 system in combination with an old primary

Page 32

1 antibody," and then two, his comment that "any
 2 trial of a new technique need to be done in
 3 parallel with a well-established one before a
 4 switch could be safely made."
 5 Were you aware of the significance of
 6 what Dr. Khalifa was saying to you about using
 7 an old antibody with a new detection kit?
 8 MR. GULLIVER:
 9 A. Again, you know, I don't ever remember
 10 receiving this memo, you know, 11 years ago,
 11 and I really can't give you anything more than
 12 I've already testified because I don't
 13 remember even discussing this with Dr.
 14 Khalifa.
 15 BROWNE, Q.C.:
 16 Q. Putting aside--and I recognize that, the
 17 notion of what he's talking about here, you
 18 know, an old primary antibody with a new
 19 detection kit, do you realize the significance
 20 of what he's talking about here, this notion
 21 of a problem -
 22 MR. GULLIVER:
 23 A. I certainly do now, yes.
 24 BROWNE, Q.C.:
 25 Q. Okay, and in fact, if we look at Ms.

Page 33

1 Wegrynowski's report, she talks about that
 2 whole notion as well, the use of validating
 3 and optimizing and making sure that there's a
 4 parallel testing. That's a critical value in
 5 IHC, is it not?
 6 MR. GULLIVER:
 7 A. Well, Trish is talking about parallel testing.
 8 If you're going to switch, say, from DAKO to
 9 Ventana or you're going to switch antibodies
 10 to do validation.
 11 BROWNE, Q.C.:
 12 Q. Right.
 13 MR. GULLIVER:
 14 A. Dr. Khalifa is talking about moving from a
 15 biochemistry, biochemical assay to an IHC
 16 assay. So it's a difference there.
 17 BROWNE, Q.C.:
 18 Q. Okay, so you view this as making a switch. I
 19 read this as one kit to another kit using the
 20 old antibody from an old kit with a new
 21 detection system. You don't view it that way?
 22 MR. GULLIVER:
 23 A. When he's talking about here, "any trial with
 24 new technique needs to be done in parallel
 25 with a well-established one -

Page 34

1 BROWNE, Q.C.:
 2 Q. Um-hm.
 3 MR. GULLIVER:
 4 A. - before a switch can be safely made." By
 5 this point in time, we have no established
 6 method, except for the biochemical assay in
 7 chemistry.
 8 BROWNE, Q.C.:
 9 Q. Okay. But going back to the previous comment,
 10 "new detection system in combination with an
 11 old primary antibody." Ms. Wegrynowski talks
 12 about the importance of making sure that the -
 13 MR. GULLIVER:
 14 A. Yes, I have to agree with it, yes.
 15 BROWNE, Q.C.:
 16 Q. Now another area I was unclear on, Mr.
 17 Gulliver, is you had mentioned on several
 18 occasion to Ms. Chaytor that your
 19 understanding of the reporting of ER/PR was
 20 that a negative result was zero, zero. That
 21 was negative to you. Did I capture that
 22 correctly?
 23 MR. GULLIVER:
 24 A. Zero, zero is negative.
 25 BROWNE, Q.C.:

Page 35

1 Q. Yes, it was a negative. Now in 1997/1998,
 2 there were a number of meetings where Dr.
 3 Khalifa, I guess, introduced the notion of
 4 making the switch over from biochemical assay
 5 to immunohistochemistry reporting for IHC, and
 6 there was a number of discussions surrounding,
 7 I guess, how that would occur and reporting
 8 and how it would be reported. Do you recall
 9 attending those meetings?
 10 MR. GULLIVER:
 11 A. I don't remember attending specific meetings.
 12 It might have been just things in discussion
 13 with Dr. Khalifa.
 14 BROWNE, Q.C.:
 15 Q. Right. There were a number of site chief
 16 meetings and I can take you through them. I
 17 have one, two, three, four, five, between 1997
 18 and 1998 where you were in attendance and this
 19 issue was discussed and including the 30
 20 percent cut off. Do you recall anything from
 21 those meetings about that discussion, how the
 22 30 percent cut off was arrived at, the
 23 discussions between St. Clare's and the Health
 24 Sciences Centre?
 25 MR. GULLIVER:

Page 36

1 A. I don't offhand right now, anything specific -
 2 BROWNE, Q.C.:
 3 Q. But you -
 4 MR. GULLIVER:
 5 A. - discussion there.
 6 BROWNE, Q.C.:
 7 Q. - you wouldn't have remembered that from when
 8 this came up in 2005, being at those meetings,
 9 the information that was disseminated among
 10 the pathologists where you were there?
 11 MR. GULLIVER:
 12 A. If you have to show me the minutes -
 13 BROWNE, Q.C.:
 14 Q. Okay, sure. Well then, let's start with the
 15 first and that's May 13, 1997, and that's P-
 16 2351. Oh, sorry, maybe--let me just see. No,
 17 that can't be right. Let me try, sorry,
 18 Registrar, 1856. Yes, okay. My apologies,
 19 Mr. Gulliver. And you'll see, right there.
 20 Now just to go back, those in attendance,
 21 you'll see you're listed.
 22 MR. GULLIVER:
 23 A. Yeah, I see that, yeah.
 24 BROWNE, Q.C.:
 25 Q. Okay, and that's May 13, 1997, and then you'll

Page 37

1 see there's an extensive minute there about
 2 Dr. Khalifa reporting to the committee about
 3 his correlation and then about how results are
 4 reported and that there will be a consensus
 5 among pathologists. "Such a meeting will be
 6 held in June" and then it was agreed to, so
 7 that "individual pathologists reporting these
 8 receptors and need for standardized criteria
 9 to determine what is positive and negative."
 10 Again, does this -
 11 MR. GULLIVER:
 12 A. I can't--I don't remember this -
 13 BROWNE, Q.C.:
 14 Q. So you don't remember being at -
 15 MR. GULLIVER:
 16 A. - discussion from ten years ago, no.
 17 BROWNE, Q.C.:
 18 Q. And then P-1857, again, I think you're there
 19 present. This is in June of 1997. You're
 20 listed as being present again, and there's
 21 further discussion surrounding the reporting
 22 of ER/PR. Again, no recollection about the
 23 discussions at this meeting either, Mr.
 24 Gulliver?
 25 MR. GULLIVER:

Page 38

1 A. No.
 2 BROWNE, Q.C.:
 3 Q. Just take a moment, sorry, and I'll just -
 4 MR. GULLIVER:
 5 A. I'm reading other -
 6 BROWNE, Q.C.:
 7 Q. Yes, and I apologize. It's 3.4 there.
 8 MR. GULLIVER:
 9 A. - other parts of the minutes here to see if
 10 there's something else.
 11 BROWNE, Q.C.:
 12 Q. Yes, if anything around that would refresh.
 13 MR. GULLIVER:
 14 A. Yeah.
 15 BROWNE, Q.C.:
 16 Q. By all means then, use the mouse, if you wish,
 17 to just -
 18 MR. GULLIVER:
 19 A. Again, this one here, I'm not in attendance?
 20 Yes.
 21 BROWNE, Q.C.:
 22 Q. This is--okay, you're not there, okay. Then
 23 let's, if we could, move to P-2413? Now would
 24 you receive minutes nonetheless as being the
 25 manager?

Page 39

1 MR. GULLIVER:
 2 A. Sometimes, but I can't say all the time.
 3 BROWNE, Q.C.:
 4 Q. Okay. This is now December 17th, sorry, 16th,
 5 1997, and you'll see here again, I thought
 6 there was a reference here. Let me just--I
 7 must have missed that, sorry. Item number
 8 three, yes, okay. Item number three here.
 9 Sorry, it wasn't headed--"steroid receptors
 10 assessment and paraffin sections. Dr. Khalifa
 11 discussed the issue further and suggested
 12 pathologists start reporting their own cases.
 13 A suggestion was made that Dr. Khalifa write
 14 up a proposal with criteria cut off values
 15 distributed to various pathologists and ask
 16 them for their feedback." Does this -
 17 MR. GULLIVER:
 18 A. I do remember it being, at some point, where
 19 they were discussing, you know, where all the
 20 other pathologists now will start doing their
 21 own interpretation.
 22 BROWNE, Q.C.:
 23 Q. Do you recall--and we'll go to the next, I
 24 think it's 2416, which is the January meeting,
 25 and I understand from--I stand to be

Page 40

1 corrected--I think you are present at this
 2 one. This meeting, this was a meeting Dr.
 3 Khalifa actually made a draft proposal and it
 4 was distributed at this meeting about the
 5 reporting and how it would be reported and 30
 6 percent cut off was used. Do you recall that,
 7 ever seeing that proposal or in fact, later on
 8 the final version of that, at any of these
 9 meetings?
 10 MR. GULLIVER:
 11 A. I don't remember seeing it at the meeting, no,
 12 but I do remember, you know, at this time, you
 13 know, Dr. Khalifa who had been doing pretty
 14 well most of the ER/PR interpretations, that
 15 you know, I guess we're getting to that
 16 literature suggests 30 percent.
 17 BROWNE, Q.C.:
 18 Q. Right.
 19 MR. GULLIVER:
 20 A. I mean, that's Dr. Khalifa is the one that had
 21 suggested that, yes.
 22 BROWNE, Q.C.:
 23 Q. Right. So you were--I guess that's what I'm
 24 trying to understand here now. You were
 25 familiar about that discussion around it

Page 41

1 being, the 30 percent being the cut off as
 2 being a correlation to negative in biochemical
 3 assay?
 4 MR. GULLIVER:
 5 A. Yes.
 6 BROWNE, Q.C.:
 7 Q. So you do recall that being discussed around
 8 that time?
 9 MR. GULLIVER:
 10 A. Yeah. Exactly which meeting, you know, or
 11 which time frame, I can't tell you exactly.
 12 BROWNE, Q.C.:
 13 Q. Sure, no, and I appreciate, there were a
 14 number--as I've taken you through here, and
 15 there are a number of others, but I guess my
 16 question goes back to your understanding of
 17 zero, zero being negative. This seems to be
 18 somewhat at odds with what was being discussed
 19 around this time among the pathologists with
 20 the 30 percent.
 21 MR. GULLIVER:
 22 A. The 30 percent was a cut off that they were
 23 talking about for that the oncologists would
 24 use. I mean, I'm going back to a zero, zero,
 25 a lab test. If there's no staining, it's

Page 42

1 negative. If there is staining, well, it's
 2 positive. It's trying to decide what
 3 percentage of tumour cells are positive.
 4 BROWNE, Q.C.:
 5 Q. Right, and you understood that that, that all
 6 that sort of discussion that had occurred
 7 previously, despite, I guess, what you had
 8 learned in terms of the basic lab training of
 9 zero means negative, you were familiar with
 10 what discussions had occurred in 1997/1998?
 11 MR. GULLIVER:
 12 A. I was familiar with Dr. Khalifa was talking
 13 about the 30 percent was a correlation to the
 14 biochemical assay.
 15 BROWNE, Q.C.:
 16 Q. And there are others there as well where this
 17 is all discussed, but thank you, Mr. Gulliver,
 18 I think you've clarified that for me. Now Ms.
 19 Chaytor asked you about the position of the
 20 quality management manager position and I
 21 think you had said you had raised this with
 22 Dr. Williams around 2001/2002. When the
 23 external reviewers were here, did this ever
 24 come up about the notion of having a quality
 25 position within the lab, either with Dr.

Page 43

1 Banerjee or Dr. Wegrynowski or Ms.
 2 Wegrynowski?
 3 MR. GULLIVER:
 4 A. A quality manager?
 5 BROWNE, Q.C.:
 6 Q. Yes, or having someone in the lab responsible
 7 for quality.
 8 MR. GULLIVER:
 9 A. Do you mean in the lab or in pathology lab?
 10 BROWNE, Q.C.:
 11 Q. Well, in the pathology lab or in the lab
 12 itself, either.
 13 MR. GULLIVER:
 14 A. Because our quality manager, you know, it's
 15 for the whole Laboratory Medicine program.
 16 BROWNE, Q.C.:
 17 Q. Right, right.
 18 MR. GULLIVER:
 19 A. It's not just for pathology.
 20 BROWNE, Q.C.:
 21 Q. Sure. Did that whole notion ever come up with
 22 either of the reviewers?
 23 MR. GULLIVER:
 24 A. Not as a dedicated quality manager, but we had
 25 talked about a technologist being dedicated

Page 44

1 for quality in pathology.
 2 BROWNE, Q.C.:
 3 Q. And did you discuss with either of the
 4 reviewers about your sort of previous thoughts
 5 along that line in previous years to
 6 management?
 7 MR. GULLIVER:
 8 A. I don't--well, I didn't have a lot of
 9 discussions with them. I mean, they were in
 10 for a very set time and they had--you know,
 11 they had, I guess, a job to perform, to do
 12 their review. So I mean, we didn't discuss
 13 all aspects. It was -
 14 BROWNE, Q.C.:
 15 Q. Or did you point out to them, "look, I have
 16 been trying to sort of get quality position
 17 here in the lab for a number of years, but
 18 just haven't been successful"?
 19 MR. GULLIVER:
 20 A. I think with Trish, both myself and Mr. Dyer,
 21 and we pointed out a significant number of
 22 things that we would hope that she would
 23 include in her final report.
 24 BROWNE, Q.C.:
 25 Q. Did you specifically say "look, we have been

Page 45

1 trying to do this for years, but we weren't
 2 successful"?

3 MR. GULLIVER:

4 A. I may have. I may not have. I can't tell
 5 you.

6 BROWNE, Q.C.:

7 Q. We've heard as well, Mr. Gulliver, about, I
 8 guess, from actually Mr. Green when he
 9 testified, the different types of slides that
 10 were being used for--at St. Clare's and the
 11 Health Sciences and that he, as we understand
 12 it, had been at St. Clare's, transferred over
 13 after Ms. Welsh had left over at the Health
 14 Sciences, and he recognized when he was over
 15 at the Health Sciences being trained in for -

16 MR. GULLIVER:

17 A. Ken was there with Ms. Welsh.

18 BROWNE, Q.C.:

19 Q. Right.

20 MR. GULLIVER:

21 A. Les Simms moved over when Ms. Welsh left.

22 BROWNE, Q.C.:

23 Q. Right. That the Health Sciences were using
 24 special slides for IHC where St. Clare's
 25 slides were, I guess, normal adalin slides

Page 46

1 were being used and that he recognized there
 2 as a result that it could probably cause more
 3 background staining. Was there--who would
 4 have been--again, to come back to my previous
 5 question to you. Who would have been
 6 responsible for ordering slides for, I guess,
 7 at that point, the Health Care Corporation?

8 MR. GULLIVER:

9 A. No, at that point, it's St. Clare's has a
 10 separate manager. For most years, it was John
 11 Murphy. And again, I can't answer your
 12 question because, you know, I don't know about
 13 the bench level operations at St. Clare's
 14 pathology and St. Clare's pathology or the
 15 bench level operations of chemistry in
 16 Carbonear. That question needs to go to the
 17 technologists or, I guess, to the division
 18 manager.

19 BROWNE, Q.C.:

20 Q. Right, but I guess my question is more
 21 directed at the fact that Health Sciences
 22 Centre is the referral lab for IHC for the
 23 province, okay, and obviously there was some
 24 recognition, from what Mr. Green was saying,
 25 that special slides were needed for IHC. Was

Page 47

1 that communicated out to the other labs in the
 2 province?

3 MR. GULLIVER:

4 A. I don't know what he means by special slides.
 5 I know the IHC, at some point, I don't know
 6 which company, they came out with another
 7 slide, I think it was called Histogrip. They
 8 were more expensive than your regular slides
 9 used every day. And what that did was create
 10 a positive charge in your slide and it helped
 11 keep your tissue on the slide. I don't think
 12 it had anything to do with background
 13 staining. But then, most labs who were
 14 sending their blocks, they would send their
 15 blocks to the Health Sciences. The Health
 16 Sciences would actually cut the slides on
 17 those slides. So if Corner Brook wanted an
 18 IHC test done, they just sent the paraffin
 19 block in and if there's 20 slides to be
 20 created, the lab at the Health Sciences
 21 created the slides, and I'm kind of thinking,
 22 again I can't be 100 percent sure, Mr. Browne,
 23 I know that at one--I think St. Clare's used
 24 to cut--the techs at St. Clare's used to cut
 25 their own blocks and just send the unstained

Page 48

1 slides to Health Sciences, and I think Mr.
 2 Dyer stopped that practice when he became the
 3 manager for the city and just told St. Clare's
 4 to send your blocks as anybody else, and let
 5 the Health Sciences Lab cut your blocks,
 6 because the slides were at the Health
 7 Sciences.

8 BROWNE, Q.C.:

9 Q. Okay, and that would have occurred for all
 10 labs around the province?

11 MR. GULLIVER:

12 A. Yes.

13 BROWNE, Q.C.:

14 Q. The procedure would be that they would send in
 15 the blocks so they would be cut -

16 MR. GULLIVER:

17 A. Yes.

18 BROWNE, Q.C.:

19 Q. So the same uniform slide would be -

20 MR. GULLIVER:

21 A. Slides would be used, yeah.

22 BROWNE, Q.C.:

23 Q. We've also heard about the use of formalin
 24 and, I guess, as I understand it, 2003, there
 25 was a switch from in-house preparation to the

Page 49

1 commercial use of formalin. Was there a
 2 particular--at least while you were a manager,
 3 presumably this was occurring, it would be
 4 bulk formalin would be purchased and then
 5 mixed in house, and we heard from Mr. Hewlett
 6 and Mr. Parks about sort of the steps that are
 7 necessary to making your in-house preparation.
 8 Was there a procedure in place, a documented
 9 procedure in place for mixing in-house
 10 formalin while you were the manager?
 11 MR. GULLIVER:
 12 A. Yes, yeah.
 13 BROWNE, Q.C.:
 14 Q. Was there--and we also heard about the
 15 importance of measuring the pH and so on. Was
 16 all this set out in some sort of policy or
 17 protocol for -
 18 MR. GULLIVER:
 19 A. For the making of your ten percent buffered
 20 formalin?
 21 BROWNE, Q.C.:
 22 Q. Yes.
 23 MR. GULLIVER:
 24 A. There was a set procedure, you know. It's
 25 pretty well a mixture of two different

Page 50

1 powders, a mixture of your concentrated
 2 formaldehyde and then added to--basically to
 3 water.
 4 BROWNE, Q.C.:
 5 Q. What were the two powders that were used, do
 6 you know?
 7 MR. GULLIVER:
 8 A. Well, I haven't done it in 20 years. I'm
 9 thinking sodium--sodium monobasic and sodium
 10 phosphate dibasic. And again, you know, what
 11 you have in your textbook is that your target
 12 is pretty well a pH around seven. So the text
 13 book would tell you to get a pH of seven using
 14 20 litres of water, you had to add I think it
 15 was two litres of concentrated formaldehyde.
 16 You had to add then so many grams mixed in
 17 water, premixed in water, of one powder and
 18 the second one, you added all three together
 19 and then that would give you your neutral ten
 20 percent buffered formalin.
 21 BROWNE, Q.C.:
 22 Q. And then was that--was there sort of a set
 23 process in place to measure the pH of the
 24 formalin?
 25 MR. GULLIVER:

Page 51

1 A. I don't think we ever measured it, no, but the
 2 formula that was given you by the textbook was
 3 for 7.0 pH.
 4 BROWNE, Q.C.:
 5 Q. Around 2003 as well, and you spoke to this on
 6 a number of questions from Ms. Chaytor about
 7 the centralization of lab services, and this
 8 had been--I think you indicated had been an
 9 issue or at least on the table for discussion
 10 since 1998 and then when Mr. Dyer became
 11 manager in 2000, 2003, the issue was brought
 12 forth once again.
 13 MR. GULLIVER:
 14 A. I'm assuming you mean centralization of
 15 pathology services.
 16 BROWNE, Q.C.:
 17 Q. Yes, yes, and that's one of the--one
 18 clarification I want to--when you say
 19 centralization of pathology services, as a
 20 layperson, am I understanding that that, you
 21 mean both the technology side and the
 22 pathologist side being moved to one site or
 23 are you just talking about the technology
 24 side?
 25 MR. GULLIVER:

Page 52

1 A. The original '98 was to have one lab for the
 2 city of St. John's.
 3 BROWNE, Q.C.:
 4 Q. Right, but pathologists would remain on both
 5 sites. Is that -
 6 MR. GULLIVER:
 7 A. No.
 8 BROWNE, Q.C.:
 9 Q. No.
 10 MR. GULLIVER:
 11 A. Originally in '98, the discussion was the
 12 Grace Hospital was closing, the Janeway was
 13 closing. The Lab Medicine program had made a
 14 decision to have--to consolidate and have one
 15 microbiology lab for the City of St. John's,
 16 and again, there was a proposal put forward to
 17 have one pathology lab for the City of St.
 18 John's.
 19 BROWNE, Q.C.:
 20 Q. I guess both then and in 2003, where was it
 21 envisioned that the pathologists would end up
 22 at the Health Sciences? I understand now that
 23 they still can't move because of--even though
 24 that's desirable, they still can't move
 25 because of space issues. How was that sort of

Page 53

1 envisaged?

2 MR. GULLIVER:

3 A. Well, the Grace had not closed. The Janeway

4 had not closed. There were plans ongoing to

5 renovate the space at the Health Sciences, and

6 it would have been pretty well an issue where

7 you may have moved one service out of St.

8 Clare's and moved something out of the Health

9 Sciences to go to St. Clare's in order to

10 accommodate like a pathology consolidation.

11 BROWNE, Q.C.:

12 Q. Was there sort of a set plan as to how all

13 that would occur?

14 MR. GULLIVER:

15 A. Back in 1998?

16 BROWNE, Q.C.:

17 Q. Or in 2003 even.

18 MR. GULLIVER:

19 A. In 2003/2004 when it was being discussed,

20 well, we had not gotten to the planning stages

21 with Facilities Management because we didn't

22 have agreement to even go that far.

23 BROWNE, Q.C.:

24 Q. Okay, and just dealing with that point, do you

25 recall some of the--you mentioned one of the--

Page 54

1 from your perspective, there was, you felt Dr.

2 Cook, there was a cultural concern about what

3 would happen to St. Clare's and there were

4 rumours around that time that St. Clare's

5 would move--sorry, would close. Was there

6 any--do you recall any discussions with Dr.

7 Cook about concerns over having quality

8 assurance issues about transportation of

9 specimens?

10 MR. GULLIVER:

11 A. I think that was one of Dr. Cook's issues

12 where if we did move parts of pathology

13 services, it would require specimens from St.

14 Clare's having to be transported across the

15 city.

16 BROWNE, Q.C.:

17 Q. Right.

18 MR. GULLIVER:

19 A. To be processed, embedded, cut and stained at

20 the Health Sciences and then slides returned

21 over there for interpretation.

22 BROWNE, Q.C.:

23 Q. And in fact, did Dr. Cook ask for and receive

24 a quality initiatives review of that whole

25 scheme to make sure that that was what -

Page 55

1 MR. GULLIVER:

2 A. Well that was more of a risk management

3 assessment.

4 BROWNE, Q.C.:

5 Q. Right.

6 MR. GULLIVER:

7 A. To ensure that that would not be an issue.

8 BROWNE, Q.C.:

9 Q. Did Dr. Cook also raise issues about sort of

10 how surgery would interface with pathology,

11 given that there was a large degree of surgery

12 still occurring at St. Clare's if that were to

13 occur as well?

14 MR. GULLIVER:

15 A. Well obviously, I mean, as I testified at some

16 point, myself and Dr. Cook met with George

17 Tilley, the CEO; Dr. Bob Williams, and these

18 are some of the concerns Dr. Cook was putting

19 forward of why we should not move services

20 from St. Clare's and obviously to allay some

21 of those concerns, we had engaged both risk

22 management, like Heather Predham and we had

23 engaged management engineering to do sort of

24 an operations review and again, you know, one

25 of Dr. Cook's concerns was the transport of

Page 56

1 specimens across the city of St. John's. And

2 another issue was about having on-site

3 pathologists with surgeons.

4 BROWNE, Q.C.:

5 Q. And that was the importance of having frozen

6 sections and doing frozen sections and so on,

7 in consult in terms of -

8 MR. GULLIVER:

9 A. I don't know about the frozen sections, but

10 again, you know, across the country there are

11 multiple, multiple organizations who have

12 moved to one pathology lab for the city and

13 pathologists would then, on an out-call basis,

14 go back to a certain site to do an on-site

15 frozen section. And, you know, I have to say

16 that while, you know, Dr. Cook did have his

17 concerns about, you know, transporting

18 specimens across the city, however, you know,

19 he put a process in place where we transport

20 specimens to Dynacare in Ottawa every day. So

21 on one side he was against sending specimens

22 from St. Clare's to Health Sciences and then

23 on the other side, you know, we're sending

24 specimens on an average of 500 a month to

25 Dynacare in Ottawa for pathologist

1 interpretation.

2 BROWNE, Q.C.:

3 Q. No, but coming back to Dr. Cook's concerns,

4 once he had those reviews done, did he not

5 agree with the proposal once those reviews

6 were conducted? And in fact, we saw

7 documentation--the Commission has seen

8 documentation where he in fact went to the MAC

9 and -

10 MR. GULLIVER:

11 A. That was like in 2005. Once the reviews were

12 done, we met with George Tilley and Dr.

13 Williams and there was no decision from

14 executive to go ahead and do a consolidation

15 of pathology. I think that might be May '04

16 and at some point after that, we do move the

17 technical component from pathology to the

18 Health Sciences and consolidate that

19 component.

20 BROWNE, Q.C.:

21 Q. As I understand, there's still not available--

22 there's no space available to bring

23 pathologists over to the -

24 MR. GULLIVER:

25 A. We now have detailed plans in place, as you

1 Q. Sure. Now you were shown as well Dr.

2 Ejeckam's memos both for April, May and June

3 of 2003. You testified yesterday you weren't

4 made aware of the first two, the April and

5 May, but if we look at both of those

6 documents, not necessary, you will see that

7 Mr. Dyer was copied on both of those.

8 MR. GULLIVER:

9 A. I think he copied--he addressed it to a number

10 of people, pathologists -

11 BROWNE, Q.C.:

12 Q. Right, pathologists and technical staff and

13 cc'd to Mr. Dyer and technologists.

14 MR. GULLIVER:

15 A. - and I think he cc'd the technologists and

16 Mr. Dyer, yes.

17 BROWNE, Q.C.:

18 Q. So in terms of your order of command, Mr. Dyer

19 would have had the responsibility to bring

20 that to your attention.

21 MR. GULLIVER:

22 A. Or Dr. Cook as the clinical chief on the

23 leadership team with him.

24 BROWNE, Q.C.:

25 Q. But in terms of direct, in terms of the sort

1 are probably well aware, with facilities

2 management now to do the physical construction

3 to accommodate that move. But again, I mean,

4 and I've said this to Ms. Chaytor, you know, I

5 know Dr. Cook for a long time was against the

6 pathology consolidation, but I really believe

7 that, you know, Dr. Cook was concerned about

8 St. Clare's--St. Clare's hospital, as were

9 many physicians at St. Clare's in that, you

10 know, you pull out pathology, what's going to

11 go next, you know, then goes DI, then goes

12 something else and then what is left at St.

13 Clare's as a, you know, as a physical building

14 or as a full hospital operation and that's

15 really where I believe his biggest concern

16 was.

17 BROWNE, Q.C.:

18 Q. And that was where I think he testified that

19 he wanted a strategic plan overall in terms of

20 what was going to happen, do you recollect -

21 MR. GULLIVER:

22 A. I think he wanted a plan for, you know, health

23 care services for the city of St. John's, not

24 just labs.

25 BROWNE, Q.C.:

1 of set up, Mr. Dyer would have been -

2 MR. GULLIVER:

3 A. Reported directly to me, yes.

4 BROWNE, Q.C.:

5 Q. And again, I don't necessarily wish--if you

6 wish, you can bring up the memo, but in the

7 June 19th, 2003 memo, Ms. Chaytor went through

8 that extensively with you. I got the sense

9 that Dr. Ejeckam was also suggesting that or

10 recommending that technologists be given time

11 and resources to learn more. Did you get that

12 sense from reading that June 19th, 2003 memo?

13 MR. GULLIVER:

14 A. No, I got the sense from him talking directly.

15 BROWNE, Q.C.:

16 Q. Either way, it was clear from Dr. Ejeckam's

17 point of view that technology should be given

18 time and resources to learn more about IHC and

19 -

20 MR. GULLIVER:

21 A. He wanted to free up some of their duties,

22 even though we didn't have the workload to

23 support three fulltime techs in IHC. What he

24 was saying was that he wanted them to have

25 time to be able to spend fulltime in IHC and

Page 61

1 give them the opportunity if they wanted to
 2 learn more. And I think Dr. Ejeckam wanted to
 3 teach them more and I think what he wanted to
 4 teach them was to start reading things in a
 5 microscope and start reading control slides,
 6 so that they would be able to troubleshoot
 7 anything at that end, as opposed to on the
 8 pathologist end.
 9 BROWNE, Q.C.:
 10 Q. And in terms of that, just sort of from the
 11 technologist's point of view, after receiving
 12 this letter from your discussions with Dr.
 13 Ejeckam, did you give thought to sort of--
 14 we've heard, the Commissioner has heard the
 15 notion of protected time and so on, of giving
 16 the technologists protected time and access to
 17 journals and subscriptions to journals, to
 18 learn more about IHC and the theory of IHC as
 19 a result of what Dr. Ejeckam suggested in
 20 2003?
 21 MR. GULLIVER:
 22 A. Well Dr. Ejeckam never ever came back with any
 23 kind of outline or plan of this is the kinds
 24 of things he would like the technologists to
 25 learn.

Page 62

1 BROWNE, Q.C.:
 2 Q. Could you not have done that on your own
 3 without talking to and in terms of saying,
 4 well Dr. Ejeckam -
 5 MR. GULLIVER:
 6 A. Again, I'm not the manager over there, I mean,
 7 I'm the director.
 8 BROWNE, Q.C.:
 9 Q. Okay, so that would have been the manager's
 10 responsibility to go to him and say, okay, can
 11 you show me what journals, can you show me
 12 where they can -
 13 MR. GULLIVER:
 14 A. Yes.
 15 BROWNE, Q.C.:
 16 Q. Was there any discussion about sort of going
 17 to Dr. Ejeckam and sitting down with him and
 18 organizing that type of plan?
 19 MR. GULLIVER:
 20 A. Dr. Ejeckam sat in my office with myself and
 21 Mr. Dyer and we talked about the whole memo
 22 and Dr. Ejeckam pretty--his thing was, he
 23 wanted the technologists to have more time in
 24 the IHC lab so he could spend time with them
 25 and he could actually teach them new skills in

Page 63

1 IHC. He didn't talk about the technologists
 2 getting more basic training in IHC theory. He
 3 talked about him wanting to have time to spend
 4 with the technologists.
 5 BROWNE, Q.C.:
 6 Q. But putting aside Dr. Ejeckam's own
 7 initiatives, what about from your end in terms
 8 of either you or Mr. Dyer looking at this and
 9 saying, okay, well what can we do to sort of
 10 escalate the knowledge of our technologists,
 11 either with protected time, with journals,
 12 like a journal club, interactions with
 13 colleagues and we saw from Ms. Wegrynowski's
 14 report the ability to interact with their
 15 peers in other institutions to learn -
 16 MR. GULLIVER:
 17 A. That would have to be outside Newfoundland
 18 because they're the only ones in Newfoundland
 19 doing the testing.
 20 BROWNE, Q.C.:
 21 Q. Sure, I appreciate that, but that whole notion
 22 is taking upon yourselves to sort of look at
 23 organizing a plan, independent of what Dr.
 24 Ejeckam was saying, for technologists?
 25 MR. GULLIVER:

Page 64

1 A. No, I mean, if Dr. Ejeckam would have done an
 2 assessment, he'd be able to bring something
 3 forward, it certainly would have been
 4 supported by myself and Mr. Dyer.
 5 BROWNE, Q.C.:
 6 Q. We saw as well around this time, the letter
 7 that was sent to Ms. Butler and Mr. Dyer from
 8 the DAKO representative and if you wish, you
 9 can refer to it, it's Exhibit P-2155. Was
 10 there any thought, again on the technologist
 11 side because we've heard from Mr. Hewlett and
 12 Mr. Parks about this, the notion that
 13 communicating that information in a similar
 14 memo to lab directors around the island--from
 15 the technology side, putting aside what Dr.
 16 Ejeckam is doing, because I understood from
 17 Mr. Parks and Mr. Hewlett as well independent
 18 of the pathologist's role in fixation that
 19 technologists also have a role in sort of
 20 recognizing and looking at blocks and looking
 21 at slides and communication back to the
 22 pathologist. Was there any thought sort of
 23 communicating that information, where you're
 24 again, the referral centre, to other labs
 25 around the island, that information piece?

Page 65

1 MR. GULLIVER:
 2 A. You mean this letter from DAKO?
 3 BROWNE, Q.C.:
 4 Q. And, well also saying the notion of, I think
 5 he talks about here in terms of to get some
 6 guidelines from other hospitals, going out and
 7 getting information from them. Do you see
 8 that there?
 9 MR. GULLIVER:
 10 A. I know, they're suggesting that we, as in the
 11 Health Sciences, as in the IHC lab -
 12 BROWNE, Q.C.:
 13 Q. Uh-hm.
 14 MR. GULLIVER:
 15 A. - should provide guidelines to the other
 16 hospitals.
 17 BROWNE, Q.C.:
 18 Q. Right.
 19 MR. GULLIVER:
 20 A. In how to fix and how to properly fix their
 21 specimens and Dr. Ejeckam did that.
 22 BROWNE, Q.C.:
 23 Q. Okay, but what about in terms of commun--he
 24 sent it to pathologists, but what about that
 25 sort of closing the loop from your side as the

Page 66

1 technical arm of this whole process, to your
 2 colleagues around the island, again
 3 emphasizing that information?
 4 MR. GULLIVER:
 5 A. Well I guess Dr. Ejeckam didn't even give me a
 6 copy as a director sitting in the lab with
 7 him, so you're saying to me I should have sent
 8 this memo then to other administrative
 9 directors in the province?
 10 BROWNE, Q.C.:
 11 Q. No, no, what I'm saying is the information--
 12 Mr. Dyer got Dr. Ejeckam's two memos. Mr.
 13 Dyer also got this information from DAKO. Was
 14 there any thought given to sort of
 15 communicating again or reinforcing what Dr.
 16 Ejeckam had said in his memos from the
 17 technical side, where you're -
 18 MR. GULLIVER:
 19 A. Well I think when I seen Dr. Ejeckam's second
 20 memo, I mean, he sent it to all pathologists,
 21 you know, and it was an excellent memo and he
 22 outlines the importance of fixation and gives
 23 him proper protocols and interpretation
 24 guidelines, I don't know how receiving
 25 something else from the manager or from

Page 67

1 technologists was going to do anything
 2 different.
 3 BROWNE, Q.C.:
 4 Q. You were shown a memo that you wrote to Dr.
 5 Williams in 2004 following the accreditation
 6 that occurred, I think it's P-3113 and I just-
 7 -yes, the second sentence here, "We also
 8 voluntarily participated in multiple
 9 proficiency testing programs from outside
 10 agencies that assess our accuracy and quality
 11 of testing." What multiple proficiency
 12 testing programs are you referring to there,
 13 Mr. Gulliver?
 14 MR. GULLIVER:
 15 A. Again, this is writing from me, as director of
 16 Laboratory Medicine -
 17 BROWNE, Q.C.:
 18 Q. Yes.
 19 MR. GULLIVER:
 20 A. At this point in time, we are enrolled in
 21 external proficiency testing, as we are now
 22 for IHC in particular, that was taking place
 23 in, for example, tissue transplantation, flow
 24 cytometry, biochemical genetics, most parts of
 25 biochemistry, hematology, coagulation, even in

Page 68

1 pathology at that time we were enrolled in CAP
 2 and ASAP, but it was more from a pathologist
 3 side.
 4 BROWNE, Q.C.:
 5 Q. Right.
 6 MR. GULLIVER:
 7 A. As you know now, we're enrolled in external
 8 proficiency testing that assesses both the
 9 technical and the clinical side of IHC
 10 testing. At this point in time, lab medicine
 11 had enrolled in external proficiency testing
 12 for years.
 13 BROWNE, Q.C.:
 14 Q. But I guess, in terms of this statement, it's
 15 a general statement, there's no limitations on
 16 it when you're writing this to Dr. Williams.
 17 Should that have, again, recognizing it's
 18 hindsight, should you have not indicated with
 19 the exception of the technology side of the
 20 Lab Medicine Program?
 21 MR. GULLIVER:
 22 A. No, because most of the other external
 23 proficiency testing is the technology side in
 24 chemistry and hematology and genetics and -
 25 BROWNE, Q.C.:

Page 69

1 Q. I'm sorry, for IHC, that limitation should
 2 have been, because it wasn't occurring at that
 3 point in time.
 4 MR. GULLIVER:
 5 A. Well at this point in time we don't have
 6 external proficiency testing in the renal lab
 7 or IHC--I mean, there's other parts of the
 8 program that we don't have external
 9 proficiency testing in.
 10 BROWNE, Q.C.:
 11 Q. Okay, so there's no indication here as to what
 12 ones you are in and what ones you are not in,
 13 what programs are in -
 14 MR. GULLIVER:
 15 A. In this memo here, no. There isn't a detailed
 16 list of here's what we participated in or here
 17 is what we don't participate in.
 18 BROWNE, Q.C.:
 19 Q. And then finally, Mr. Gulliver -
 20 MR. GULLIVER:
 21 A. And most is from CAP.
 22 BROWNE, Q.C.:
 23 Q. Right. You were asked about the meeting of
 24 August 1st, 2005 and the discussion that
 25 occurred between yourself and Mr. Dyer and Dr.

Page 70

1 Carter.
 2 MR. GULLIVER:
 3 A. Well Mr. Dyer didn't really speak at all.
 4 BROWNE, Q.C.:
 5 Q. Okay. At that meeting, was there a
 6 representative--I think Ms. Bonnell who was
 7 the communications officer for Eastern Health
 8 at that time, was she present at that meeting?
 9 Do you recall her being there?
 10 MR. GULLIVER:
 11 A. I would assume so, I can't tell you for sure.
 12 BROWNE, Q.C.:
 13 Q. Do you recall--I guess my question more
 14 specifically in terms of do you recall at that
 15 meeting was there any discussion about--and
 16 the Commissioner has seen draft press releases
 17 and so on, do you recall any discussion about
 18 the wording of a draft press release?
 19 MR. GULLIVER:
 20 A. At that particular meeting? No, I don't. I'm
 21 not saying that we didn't, but you know,
 22 there's so many meetings in that time frame.
 23 BROWNE, Q.C.:
 24 Q. Dr. Carter has testified that one of the
 25 things that sort of concerned her at the

Page 71

1 meeting and why she voiced her opinion was
 2 that there was a discussion around that time
 3 or during that meeting about what information
 4 should go in a draft press release and she was
 5 concerned about your use of the term
 6 sensitivity--of the Ventana machine being more
 7 sensitive than the DAKO machine and so on and
 8 the implications that that may mean to the
 9 public. Do you recall any discussion around
 10 that and her challenging on that?
 11 MR. GULLIVER:
 12 A. I think I can remember something like that, I
 13 don't know if she challenged on it. I think I
 14 was being asked at the time for basic
 15 information about the Ventana, you know,
 16 system and that was one of the things that
 17 when the Ventana system was implemented, that
 18 it was more sensitive than using the old DAKO
 19 autostainer.
 20 BROWNE, Q.C.:
 21 Q. Okay. And that would have been your sort of
 22 input to, I guess, that whole discussion.
 23 MR. GULLIVER:
 24 A. It would have been a part of my input, yes.
 25 BROWNE, Q.C.:

Page 72

1 Q. Mr. Gulliver, thank you very much.
 2 MR. GULLIVER:
 3 A. You're welcome.
 4 THE COMMISSIONER:
 5 Q. Thank you, Mr. Browne.
 6 BROWNE, Q.C.:
 7 Q. Thank you, Commissioner.
 8 THE COMMISSIONER:
 9 Q. Ms. Newbury? I'm assuming you're still of the
 10 same position?
 11 MR. PRITCHETT:
 12 Q. I am Commissioner.
 13 THE COMMISSIONER:
 14 Q. All right, thank you.
 15 MR. TERRY GULLIVER, EXAMINATION BY MS. JENNIFER NEWBURY
 16 MS. NEWBURY:
 17 Q. Good morning, Mr. Gulliver.
 18 MR. GULLIVER:
 19 A. Good morning.
 20 MS. NEWBURY:
 21 Q. Jennifer Newbury for the Canadian Cancer
 22 Society, Newfoundland and Labrador division.
 23 Mr. Gulliver, yesterday you were asked if you
 24 were aware in July or August of 2005 when you
 25 were gathering together information for

Page 73

1 retesting, if anyone is going to try and
 2 figure out what happened and that's with
 3 respect to the ER/PR test results, and you
 4 responded that you would assume at some point
 5 that would be a focus that you would need to
 6 work on, but at that point in time, which is
 7 July and August, 2005, all you were focused on
 8 was trying to identify patients who could be
 9 retested and who could be offered hormone
 10 therapy. Can you recall any time between July
 11 or August, 2005 and up until the spring of
 12 2007 when the Inquiry was called, were you
 13 asked by anyone within Eastern Health to
 14 retain or collect all documentation regarding
 15 ER/PR, whether it's e-mails or letters or
 16 policies or articles or educational documents,
 17 manuals, et cetera, for the purposes of any
 18 such investigation or review or whatever that
 19 you had contemplated might very well happen?
 20 MR. GULLIVER:
 21 A. And you're saying up until July '07?
 22 MS. NEWBURY:
 23 Q. Any time between the summer of 2005 when, at
 24 that point in time you were focusing on
 25 collecting results for testing.

Page 74

1 MR. GULLIVER:
 2 A. I don't remember ever being asked to
 3 specifically, you know, collect every piece of
 4 document that you have to go to this group who
 5 are going to start assessing to try to
 6 determine, you know, what went wrong or why
 7 the results changed.
 8 MS. NEWBURY:
 9 Q. Okay.
 10 MR. GULLIVER:
 11 A. I mean, certainly, being involved in meetings
 12 after meetings after meetings, after meetings,
 13 I mean, certainly there was discussion about,
 14 well, what could have went wrong, what could
 15 have happened? Why would results change like
 16 this and I mean, you've heard through all this
 17 inquiry the multiple scenarios that could be a
 18 possibility in, you know, leading to a changed
 19 result.
 20 MS. NEWBURY:
 21 Q. Right, and I guess the focus of my question
 22 was the mechanics of trying to answer those
 23 questions and whether -
 24 MR. GULLIVER:
 25 A. And I was never asked that, no.

Page 75

1 MS. NEWBURY:
 2 Q. You were never asked by anyone to do that
 3 specifically or generally, if not said it to
 4 someone, to at the very least make sure that
 5 you don't discard any relative documentation
 6 or to-
 7 MR. GULLIVER:
 8 A. But you're asking me by an Eastern Health
 9 person.
 10 MS. NEWBURY:
 11 Q. By anyone within Eastern Health and how about
 12 outside Eastern Health?
 13 MR. GULLIVER:
 14 A. Well we were asked that by -
 15 MS. NEWBURY:
 16 Q. For the Class Action.
 17 MR. GULLIVER:
 18 A. Yes.
 19 MS. NEWBURY:
 20 Q. And on your own initiative did you ever, say
 21 back in July or August of 2005, when you had
 22 it in your mind that at some point, you know,
 23 this is something that we will probably focus
 24 on, did you take your own initiative to speak
 25 to people who you are responsible for

Page 76

1 supervising to make sure that as soon as you
 2 have an e-mail or an article or anything here
 3 that relates to ER/PR, please don't discard
 4 it? Did you take that initiative yourself?
 5 MR. GULLIVER:
 6 A. I don't remember specifically telling people
 7 don't throw anything away, no.
 8 MS. NEWBURY:
 9 Q. Okay. And you're in a transition here between
 10 Eastern Health and developing new policies,
 11 discarding, I guess, or replacing Health Care
 12 Corporation policies with Eastern Health
 13 policies, so that wasn't a concern of yours.
 14 MR. GULLIVER:
 15 A. No.
 16 MS. NEWBURY:
 17 Q. And is there any reason why you didn't think
 18 that that might be something more of looking
 19 into, just for the purposes of your Laboratory
 20 Medicine Program that you're the director of?
 21 MR. GULLIVER:
 22 A. When it comes to the policies?
 23 MS. NEWBURY:
 24 Q. Anything that relates to the ER/PR. You know
 25 you've got an issue here, you know, that right

Page 77

1 now, July, August, 2005, you're focusing on
 2 retesting, but at some point we might want to
 3 try and put our heads together and figure out
 4 what's going on. I'm just wondering whether
 5 you focused on that, I guess, somewhat of an
 6 administrative task -
 7 MR. GULLIVER:
 8 A. At that point in time, no, not at that point
 9 in time.
 10 MS. NEWBURY:
 11 Q. Mr. Gulliver, yesterday you had indicated when
 12 asked about the changed test results between
 13 1997 and 2005, and in particular your response
 14 to or your contribution to an article by
 15 Carolyn Stokes in October of 2005 and you
 16 indicated that it's your belief today that in
 17 the eight-year time frame that almost 3000
 18 patients were originally tested and assessed
 19 for treatment for hormone therapy and that
 20 three years later, after going through
 21 thousands of hours of work to identify review
 22 patients, have patients retested that could be
 23 affected, we now know that approximately 300
 24 patient's results have changed and a lesser
 25 number than that had to require a treatment

Page 78

1 change. So based on your original
 2 approximately 3000 patients, 90 percent of the
 3 patients were done correctly right from the
 4 beginning. Now, of those 3000 test results,
 5 how many were actually retested?
 6 MR. GULLIVER:
 7 A. I think you've seen documentation, there's
 8 about a little over a thousand, about one
 9 third.
 10 MS. NEWBURY:
 11 Q. So the other approximately 2000 were not
 12 retested?
 13 MR. GULLIVER:
 14 A. And as you know, they weren't retested because
 15 they were deemed to be positive, therefore,
 16 they would have been a candidate for hormone
 17 therapy.
 18 MS. NEWBURY:
 19 Q. Okay, but in terms of saying that those, all
 20 3000 tests or 90 percent of the 3000 were done
 21 correctly right from the beginning, how can
 22 you be confident that those other 2000 were
 23 done correctly from the beginning?
 24 MR. GULLIVER:
 25 A. Well I trust the opinion of the oncologist.

Page 79

1 MS. NEWBURY:
 2 Q. And what opinion is that?
 3 MR. GULLIVER:
 4 A. That, you know, they told us that if patients
 5 were positive, then you can make the
 6 assumption that those patients were either
 7 offered hormone therapy or on hormone therapy.
 8 MS. NEWBURY:
 9 Q. Okay, but in terms of whether or not the
 10 positive test result is a correct result for
 11 that patient -
 12 MR. GULLIVER:
 13 A. Well that's a different matter, I mean, I know
 14 where -
 15 MS. NEWBURY:
 16 Q. But I guess what you said yesterday and I
 17 guess the general concept that was covered off
 18 by you in your contribution to the article
 19 written by Carolyn Stokes is that 3000
 20 patients were tested over that eight-year time
 21 frame and 90 percent of those patients were
 22 done correctly right from the beginning. So
 23 it's a positive assertion that those 2000
 24 patients results that were never retested are
 25 correct and I'm just wondering what basis do

Page 80

1 you have to say that they were correct?
 2 MR. GULLIVER:
 3 A. Well I think we've seen enough submissions
 4 through the inquiry and enough evidence since
 5 then that, you know, the issue with this test
 6 is the false negatives. You know, certainly
 7 there's documentation that there could be
 8 anywhere from, you know, up to three percent
 9 false positives. I think through all this
 10 review there's been a documented, you know, a
 11 handful of patients who were originally called
 12 positive who are now being treated as a
 13 negative, you know. It's been five or six or
 14 seven, so and listen to the oncologists that,
 15 you know, patients who were originally
 16 positive were either offered or on hormone
 17 therapy, I think the issue is the false
 18 negatives, not the false positives.
 19 MS. NEWBURY:
 20 Q. So that's your understanding and nothing over
 21 the last three years has changed your mind
 22 that there is no issue with those 2000 test
 23 results that were not redone?
 24 MR. GULLIVER:
 25 A. And I think Eastern Health has made that

Page 81

1 determination also.
 2 MS. NEWBURY:
 3 Q. Okay, and have you been involved in meetings
 4 where that's been determined?
 5 MR. GULLIVER:
 6 A. I was at meetings with, you know, Eastern
 7 Health officials and oncologists and
 8 pathologists and executive, you know, in
 9 talking about should we go back and retest all
 10 the positives.
 11 MS. NEWBURY:
 12 Q. And who generally was at those meetings?
 13 MR. GULLIVER:
 14 A. At some of those meetings was Kara Laing, Joy
 15 McCarthy from the oncologist side; Dr. Denic,
 16 Dr. Cook, Pat Pilgrim, Dr. Howell, you know,
 17 myself and Heather Predham, you know, it's
 18 been -
 19 MS. NEWBURY:
 20 Q. Those are the main players.
 21 MR. GULLIVER:
 22 A. The main players we'll say, yes.
 23 MS. NEWBURY:
 24 Q. And you've indicated that in the last three
 25 years thousands of hours of work were actually

Page 82

1 spent reviewing the results of ER and I assume
 2 the positive test results, but was there any
 3 portion of time spent reviewing the--or sorry,
 4 the ER negative results, but was a portion of
 5 that thousand of hours of work actually spent
 6 reviewing the ER positive test results?
 7 MR. GULLIVER:
 8 A. No, a portion of time was reviewing the actual
 9 pathology reports where a patient was reported
 10 as positive and to ensure that, you know, if
 11 they're deemed positive, that they are
 12 positive. There was not a lot of time in
 13 ensuring the patients who were called positive
 14 are still positive, with the exception of
 15 doing some retesting to confirm that a patient
 16 who was positive was still retested positive.
 17 MS. NEWBURY:
 18 Q. So essentially once the report was identified
 19 to be a positive test result for ER, then that
 20 was put aside and that was the end of the
 21 inquiry for those particular results?
 22 MR. GULLIVER:
 23 A. For individual patients, yes, but as a
 24 positive group, there were some samples
 25 retested and confirmed positive that they were

Page 83

1 positive originally and retested positive just
 2 to kind of, you know, sort of put that aside.
 3 THE COMMISSIONER:
 4 Q. My understanding up to point had been that
 5 there were some people in the positive group
 6 who, at their request, were retested.
 7 MR. GULLIVER:
 8 A. And there has been some of those, yes.
 9 THE COMMISSIONER:
 10 Q. And there were some people who one might,
 11 depending on your point of view, put in the
 12 positive group because they might have been
 13 viewed as weak expressers and therefore,
 14 somebody would have decided they were
 15 appropriate to be testing, but are you
 16 suggesting that there was another group of
 17 people who nobody would be worried about in
 18 terms of whether or not their category is
 19 genuinely positive, who you would have at
 20 randomly rechecked?
 21 MR. GULLIVER:
 22 A. There was a group in the summer of '05, there
 23 were some patients who had tested positive,
 24 were sent off for retest and they were
 25 confirmed positive.

Page 84

1 MS. NEWBURY:
 2 Q. Perhaps I could bring up Exhibit P-1402
 3 please? This is an e-mail, you were shown
 4 this in the last day or so, Mr. Gulliver.
 5 MR. GULLIVER:
 6 A. I don't know if I've seen that one, Ms.
 7 Newbury.
 8 MS. NEWBURY:
 9 Q. Actually down here there's an embedded
 10 message, October 26, 2006. It was sent from
 11 Oscar Howell to a number of people, including
 12 yourself and there was the original one from
 13 Heather Predham to a group, including
 14 yourself, and that's dated October 26th. And
 15 in the first paragraph there, it states--a
 16 person's name has been redacted, "was
 17 diagnosed with breast cancer in 1999. Her
 18 original ER/PR was 30 and 40 percent. Upon
 19 retesting, her ER/PR was zero zero. This was
 20 rechecked twice by Mount Sinai and still no
 21 staining was revealed. The original slides
 22 were assessed by pathology and it was found
 23 that the original interpretation was accurate.
 24 She was one of the four patients that we
 25 classified as retro converters; in other

Page 85

1 words, she originally stained positive but now
 2 was coming back negative, the opposite of our
 3 concern." Now are these the patients that you
 4 were just mentioning had been tested in the
 5 summer of 2005 for whatever reason?
 6 MR. GULLIVER:
 7 A. No, I don't think so.
 8 MS. NEWBURY:
 9 Q. Okay, so there was another group of patients
 10 retested then?
 11 MR. GULLIVER:
 12 A. I think Dr. Carter had selected some positive
 13 patients, I think mostly from the Ventana
 14 system and had them retested just to be
 15 confirmed positive because there was some
 16 discussion in the summer of '05 about are we
 17 getting too many positives off the Ventana
 18 system? Is it too sensitive?
 19 MS. NEWBURY:
 20 Q. And where were they retested?
 21 MR. GULLIVER:
 22 A. I think she sent them to the Mount Sinai and
 23 they were done as like consults.
 24 MS. NEWBURY:
 25 Q. Okay, and what was your understanding as to

Page 86

1 the results of those?
 2 MR. GULLIVER:
 3 A. That they were confirmed positive.
 4 MS. NEWBURY:
 5 Q. Okay. If I could bring up Exhibit P-0125,
 6 page 42 please? This is a document that was
 7 prepared by Eastern Health for the Department
 8 of Health and Community Services in November
 9 of 2006, November 23rd. And this has, it's
 10 called "ER/PR case analysis" and has a
 11 breakdown of some numbers and are you familiar
 12 generally with the information in this
 13 particular document?
 14 MR. GULLIVER:
 15 A. I wasn't involved in that and I didn't see the
 16 document.
 17 MS. NEWBURY:
 18 Q. Okay, but are you familiar with the content of
 19 it, the numbers, the general types of -
 20 MR. GULLIVER:
 21 A. I guess in general, yes.
 22 MS. NEWBURY:
 23 Q. And if you note there under the first group,
 24 the third bullet, there is a statement that
 25 "there are confirmed positive results

Page 87

1 numbering 12" and down below, "originally had
 2 a degree of ER positivity, but on retesting
 3 was negative", that's down under the change in
 4 results section. And those are the only
 5 references there to positive test results that
 6 are specifically broken down, so that would be
 7 four, plus the 12 is 16. So 12 were confirmed
 8 positive. Now do you know if Dr. Carter's
 9 information would likely have been included in
 10 this?
 11 MR. GULLIVER:
 12 A. I don't think it is, Ms. Newbury. I think
 13 these are--this is an assessment of the
 14 patients that were sent off in the retesting.
 15 I think what Dr. Carter had done was just to
 16 have some positive cases from Ventana system
 17 confirmed positive by Mount Sinai.
 18 MS. NEWBURY:
 19 Q. So you think that that would have been
 20 excluded from -
 21 MR. GULLIVER:
 22 A. And they would not have been part of the
 23 retesting--they would be excluded from this,
 24 yes.
 25 MS. NEWBURY:

Page 88

1 Q. And if any of the preliminary results retested
 2 under the guidance of Dr. Carter had resulted
 3 in changes, would that be included in this
 4 breakdown of numbers generally speaking?
 5 MR. GULLIVER:
 6 A. You're saying if those positive Ventanas had
 7 to come back as negative?
 8 MS. NEWBURY:
 9 Q. If any results came back, because Dr. Carter
 10 wasn't only sending up positives, she was
 11 sending up a selection of results and this was
 12 before sort of the mass retesting.
 13 MR. GULLIVER:
 14 A. Right.
 15 MS. NEWBURY:
 16 Q. I'm just wondering if any of those other
 17 results would be reflected in these numbers?
 18 MR. GULLIVER:
 19 A. I would think the ones that she sent off in
 20 2002 would be in these numbers.
 21 MS. NEWBURY:
 22 Q. In 2002?
 23 MR. GULLIVER:
 24 A. Like Dr. Carter had organized about 60 cases
 25 from 2002 that were sent off, those numbers,

Page 89

1 I'm assuming would be reflected in this total
 2 number.
 3 MS. NEWBURY:
 4 Q. So you think there's a separate group of
 5 numbers -
 6 MR. GULLIVER:
 7 A. That were Ventana positive and then confirmed
 8 as positive.
 9 MS. NEWBURY:
 10 Q. And Mr. Gulliver -
 11 MR. GULLIVER:
 12 A. And there were, you know, another dozen cases
 13 I think we sent out to Montreal to try and
 14 correlate and confirming, I mean, those
 15 numbers would not be here in this retest.
 16 MS. NEWBURY:
 17 Q. And why is that?
 18 MR. GULLIVER:
 19 A. Because they were not being done to retest the
 20 patient, they were being done to compare
 21 systems.
 22 MS. NEWBURY:
 23 Q. Sort of quality assurance with the systems?
 24 MR. GULLIVER:
 25 A. Pretty well, yeah.

Page 90

1 MS. NEWBURY:
 2 Q. And are there records available of that?
 3 Perhaps I've seen them, I'm not--I don't have
 4 a clear understanding of what you're talking
 5 about.
 6 MR. GULLIVER:
 7 A. I think Ms. Predham may have those.
 8 MS. NEWBURY:
 9 Q. Okay. Mr. Gulliver, as director of the
 10 Laboratory Medicine Program, do you have
 11 access to all of the test results that were
 12 obtained as part of the retesting program in
 13 Mount Sinai or as part of Dr. Carter's own, I
 14 guess, comparison of the system?
 15 MR. GULLIVER:
 16 A. The actual results?
 17 MS. NEWBURY:
 18 Q. Yes.
 19 MR. GULLIVER:
 20 A. I didn't have the results as it was ongoing.
 21 MS. NEWBURY:
 22 Q. But you have access to it.
 23 MR. GULLIVER:
 24 A. Right now those results are in the database.
 25 MS. NEWBURY:

Page 91

1 Q. The NLCHI database?
 2 MR. GULLIVER:
 3 A. The NLCHI database.
 4 MS. NEWBURY:
 5 Q. But prior to that, prior to NLCHI's
 6 involvement, would you have had access, as the
 7 director of the Laboratory Medicine Program to
 8 these results? If you wanted to look at those
 9 for any reason to do your own analysis or what
 10 have you?
 11 MR. GULLIVER:
 12 A. If I wanted to get them, I would be able to
 13 get them, yes.
 14 MS. NEWBURY:
 15 Q. Okay, you're permitted access to that, is my
 16 question.
 17 MR. GULLIVER:
 18 A. Yes.
 19 MS. NEWBURY:
 20 Q. And you can physically, from a practical
 21 sense, you can log into a system and get it or
 22 make a request to get access to that
 23 information. Mr. Gulliver, do you today have
 24 your own idea as to the number of retro
 25 conversions and that's the term that was used

Page 92

1 in the e-mail from Heather Predham, do you
 2 know today how many retro conversions, whether
 3 it was part of Dr. Carter's assessment or the
 4 official retesting program at Mount Sinai -
 5 MR. GULLIVER:
 6 A. I can't give you an exact number, Ms. Newbury.
 7 I mean, I know originally there were four that
 8 were confirmed that were originally called
 9 positive for whatever reason, whether it was
 10 actually a true positive, whether it was a
 11 mis-call originally and now retested and came
 12 back as zero zero as a negative, and my best
 13 estimate would be that there's less than ten.
 14 MS. NEWBURY:
 15 Q. And you're alluding to there the different
 16 reasons why a test result might have been
 17 called positive and now is being called
 18 negative, so there could be an actual
 19 technical issue which gives a true false
 20 positive, is that something that you're
 21 familiar with?
 22 MR. GULLIVER:
 23 A. It could be that or it could be a
 24 misinterpretation.
 25 MS. NEWBURY:

Page 93

1 Q. Okay, and have you ever compiled a list of all
 2 retro conversions?
 3 MR. GULLIVER:
 4 A. I have not, no.
 5 MS. NEWBURY:
 6 Q. Okay, and has anyone in the lab, such as Mr
 7 Dyer compiled such a list?
 8 MR. GULLIVER:
 9 A. Not to my knowledge, Barry hasn't no. I don't
 10 know if the pathologists have.
 11 MS. NEWBURY:
 12 Q. Okay.
 13 MR. GULLIVER:
 14 A. Dr. Denic would be the best one to answer
 15 that.
 16 MS. NEWBURY:
 17 Q. Okay, now Dr. Denic does not appear to have
 18 done so. Do you know if anyone else in
 19 Eastern Health has prepared such a list?
 20 MR. GULLIVER:
 21 A. My best guess would be Ms. Predham.
 22 MS. NEWBURY:
 23 Q. Your guess, so that means you have no idea of
 24 whether she has or hasn't, is that correct?
 25 MR. GULLIVER:

Page 94

1 A. I can't tell you for sure, but I think she
 2 would be the best person to ask.
 3 MS. NEWBURY:
 4 Q. Okay. So she hasn't come to you for any
 5 information or any input on how to go about
 6 doing this? You don't have any reason to
 7 believe that she's done it?
 8 MR. GULLIVER:
 9 A. No.
 10 MS. NEWBURY:
 11 Q. And why have you not compared or compiled such
 12 a list of retro converters?
 13 MR. GULLIVER:
 14 A. I think that, I mean, that's more of a
 15 clinical issue, you know, someone like Dr.
 16 Denic, our clinical chief, would be something
 17 he would want to undertake and, you know, and
 18 review the original slides and compare them to
 19 the retest slides.
 20 MS. NEWBURY:
 21 Q. And you don't see that, as a director of the
 22 Laboratory Medicine Program, that you would
 23 have any role in helping to gather together
 24 the information?
 25 MR. GULLIVER:

Page 95

1 A. I think that Dr. Denic would ask Barry Dyer
 2 something like that, to help him organize and
 3 pull blocks of slides and do those basic
 4 things.
 5 MS. NEWBURY:
 6 Q. And are you aware of whether Dr. Denic has
 7 asked Barry Dyer to assist in that regard?
 8 MR. GULLIVER:
 9 A. I know that Dr. Denic has reviewed some retro
 10 converters.
 11 MS. NEWBURY:
 12 Q. But in terms of actually compiling a list of
 13 all of the retro converters?
 14 MR. GULLIVER:
 15 A. I can't tell you for sure if he has or has
 16 not.
 17 MS. NEWBURY:
 18 Q. And if Dr. Denic had taken it upon himself to
 19 compile such a list of retro converters, would
 20 you anticipate receiving a copy of that list?
 21 MR. GULLIVER:
 22 A. I would think that he would keep me informed,
 23 yes.
 24 MS. NEWBURY:
 25 Q. Okay, and would that be of any value or

Page 96

1 benefit to you as the director, either you or
 2 perhaps Mr. Dyer?
 3 MR. GULLIVER:
 4 A. Well I think the benefit would be, number one,
 5 how many do you have, so you know, if you--I
 6 mean, we know we have documented less than ten
 7 out of, you know, so we're talking out of 2000
 8 patients approximately, that you know, the
 9 2000 patients who were deemed to be positive
 10 and have not been retested, so within that
 11 group, you know, for whatever reason, we've
 12 identified that there may be ten or less than
 13 ten who have converted from a positive,
 14 whether it was a misinterpretation, whether it
 15 was a technical false positive and now they're
 16 retested negative. So you're talking about
 17 less than one percent of that total. If, so
 18 if Dr. Denic compiled a list, you know, and
 19 that list, Ms. Newbury, was like 200. I think
 20 then, you know, yes, that's something that you
 21 really want to be interested in if the numbers
 22 were something like that.
 23 MS. NEWBURY:
 24 Q. Okay, and is that because if you take 200 and
 25 divide that by 2000, which are the approximate

1 total of -
 2 MR. GULLIVER:
 3 A. It's 10 percent.
 4 MS. NEWBURY:
 5 Q. Ten percent, and ten percent for you would be
 6 a concern, would it?
 7 MR. GULLIVER:
 8 A. It would be, yes.
 9 MS. NEWBURY:
 10 Q. Okay. Now you're assuming that the 2000 test
 11 results that haven't been retested are all
 12 accurate?
 13 MR. GULLIVER:
 14 A. I have to say yes.
 15 MS. NEWBURY:
 16 Q. Okay.
 17 MR. GULLIVER:
 18 A. As many other people are, yes.
 19 MS. NEWBURY:
 20 Q. Okay. Now the document right here shows some
 21 results. Now unfortunately it appears from
 22 your understanding that Dr. Carter's
 23 information is not there, but based on this
 24 information, you have four out of sixteen
 25 positive test results that converted upon

1 the expected false positive rate would be
 2 anywhere from 1 to 3 percent.
 3 MS. NEWBURY:
 4 Q. Very rare, I think, was your evidence
 5 yesterday, that experts said it would be very
 6 rare to get a false positive, but my question
 7 is here you have only retested, according to
 8 this particular document, a total of sixteen
 9 positive test results, you haven't retested
 10 the approximately 2000 others that didn't get
 11 into part of this retesting program. You've
 12 only retested sixteen in total. Four of those
 13 have converted. That's not a particularly
 14 good success rate if you compare it with what
 15 the experts expected, which is one to three or
 16 very rare, and I'm just wondering whether that
 17 has caused you to delve into that issue any
 18 further than that?
 19 MR. GULLIVER:
 20 A. It has not, no.
 21 MS. NEWBURY:
 22 Q. Okay, so it doesn't concern you that the
 23 expectations of the experts has not been borne
 24 out by what's being shown here?
 25 MR. GULLIVER:

1 retesting. That's 25 percent.
 2 MR. GULLIVER:
 3 A. I know when I see this, it's reviewing 763
 4 cases.
 5 MS. NEWBURY:
 6 Q. Right.
 7 MR. GULLIVER:
 8 A. And within that 763 cases, four of them have
 9 been confirmed as a retro converter.
 10 MS. NEWBURY:
 11 Q. Yeah, but 763, those are - you know, the large
 12 bulk of that would be negative results. So a
 13 negative test result for ER doesn't tell you
 14 anything about a PR test or a positive test
 15 result for ER. So wouldn't you have to look
 16 at the actual total number of positive test
 17 results to see how are we doing here, how are
 18 we doing with conversions of positive test
 19 results?
 20 MR. GULLIVER:
 21 A. Of false positives?
 22 MS. NEWBURY:
 23 Q. Exactly.
 24 MR. GULLIVER:
 25 A. I know, and you've heard experts testify that

1 A. I think I'd be more concerned if our
 2 oncologists were concerned.
 3 MS. NEWBURY:
 4 Q. Okay. Now you haven't compiled a list of the
 5 actual retro conversions, so you can't say
 6 today here's a list, here are the exact
 7 number, your understanding is that it's fewer
 8 than ten?
 9 MR. GULLIVER:
 10 A. Yes.
 11 MS. NEWBURY:
 12 Q. And is it your understanding that that's the
 13 same information that the oncologists would
 14 have that they're relying upon to decide
 15 whether or not we should be concerned about
 16 this?
 17 MR. GULLIVER:
 18 A. No. Even before retesting started, you know,
 19 the oncologists had no concern about the
 20 patients who were already called positive.
 21 MS. NEWBURY:
 22 Q. And in that case, the retesting program
 23 started because of an ER negative test result
 24 that converted?
 25 MR. GULLIVER:

Page 101

1 A. Yes.

2 MS. NEWBURY:

3 Q. But once it was discovered that we're actually

4 getting more positive test results that are

5 converting to negative than would be expected,

6 based on what the experts say, did that cause

7 you to say, well, we should gather together

8 all of the information, all of the data on

9 these conversions, to make sure that the

10 oncologists are aware of that before they

11 decide, listen, we shouldn't be worried about

12 this? I'm just wondering whether you've

13 actually gathered together the data for that?

14 MR. GULLIVER:

15 A. I have not personally, no.

16 MS. NEWBURY:

17 Q. Or thought about doing it?

18 MR. GULLIVER:

19 A. No.

20 MS. NEWBURY:

21 Q. And you don't know that anyone else has?

22 MR. GULLIVER:

23 A. I think you should ask Ms. Predham.

24 MS. NEWBURY:

25 Q. And I will do that, I'm sure, but I'm just

Page 102

1 wondering about your particular role there as

2 the director of the laboratory medicine

3 program. On that issue of what the experts

4 have told you to expect, 1 to 3 percent, what

5 experts specifically are you talking about?

6 MR. GULLIVER:

7 A. Well, I think we've seen through literature,

8 through literature researches -

9 MS. NEWBURY:

10 Q. I'm just wondering what your understanding at

11 the time. I know there's a lot of information

12 from the literature, but prior to, say, the

13 inquiry and all of the evidence that came out

14 there, what was your understanding from 2005,

15 2006, early 2007, as to what experts - which

16 experts would have expected very rare or 1 to

17 3 percent?

18 MR. GULLIVER:

19 A. I spoke to an expert who's involved with the

20 class action, so I can't really disclose

21 anything there.

22 MS. NEWBURY:

23 Q. Okay, I don't want to go there. Is there

24 anyone else that you spoke to, any other - the

25 reviewers that were here, or anyone that you

Page 103

1 might know through your association, any

2 colleagues across the country?

3 MR. GULLIVER:

4 A. I'm just thinking in general within the lab

5 profession that, you know, false positives is

6 not something that you see.

7 MS. NEWBURY:

8 Q. That you're not supposed to see?

9 MR. GULLIVER:

10 A. It's very rare.

11 MS. NEWBURY:

12 Q. Okay.

13 MR. GULLIVER:

14 A. Very rare.

15 MS. NEWBURY:

16 Q. And if it turns out that there are more

17 instances of that, of retro conversions, which

18 contradicts what's expected by the literature

19 and by the experts, would that cause you a

20 concern?

21 MR. GULLIVER:

22 A. Certainly would. As I mentioned earlier - I

23 think what you need to be concerned with is

24 what is the reason for a false positive, why

25 was something called positive originally and

Page 104

1 now why is it retesting and there's no

2 staining.

3 MS. NEWBURY:

4 Q. And what are the things that you would look

5 for to try to ascertain what the reasons are

6 for false positives?

7 MR. GULLIVER:

8 A. I think there's two things you would have to

9 look at; was the actual test procedure - you

10 know, was the antibody being used - was it

11 being used too strongly, therefore, you're

12 giving an awful lot of background staining

13 that could be misread.

14 MS. NEWBURY:

15 Q. Okay.

16 MR. GULLIVER:

17 A. Or is it simply that the pathologist who read

18 the original slide misinterpreted plasmic

19 staining for nuclear staining and called it

20 positive.

21 MS. NEWBURY:

22 Q. Are you aware of any other possible causes,

23 such as over antigen retrieval?

24 MR. GULLIVER:

25 A. I would think that's the two main - the two

Page 105

1 main causes.
 2 MS. NEWBURY:
 3 Q. Dr. Laing gave some evidence on her knowledge
 4 of the data relating to the retro conversions,
 5 and she was shown two particular lists that
 6 contained some information about original
 7 results and retest results. If I could bring
 8 up Exhibit 1373, please.
 9 THE COMMISSIONER:
 10 Q. What was that number, please?
 11 MS. NEWBURY:
 12 Q. 1373, please. So this was a list, and you're
 13 neither the sender nor recipient of this
 14 document. It's called "Retro List", and it
 15 was sent from Heather Predham to Dr. Denic and
 16 Kara is referenced, Kara Laing is referenced
 17 in the body of the e-mail here, and attached
 18 to that are lists of several original and
 19 Mount Sinai retest results. Are you familiar
 20 with the information in that chart that's
 21 shown there?
 22 MR. GULLIVER:
 23 A. I'm not, no.
 24 MS. NEWBURY:
 25 Q. You're not.

Page 106

1 MR. GULLIVER:
 2 A. No.
 3 MS. NEWBURY:
 4 Q. Okay, so you don't recognize anything about
 5 that particular group, not the e-mail itself
 6 because I know that you weren't a recipient of
 7 that?
 8 MR. GULLIVER:
 9 A. Not that group as a group. You know,
 10 individually, if these patients were - if
 11 Heather came across these patients, you know,
 12 she may ask me to do some further
 13 documentation to ensure the Meditech system,
 14 that what the original results were and those
 15 kinds of things, but I've not been involved in
 16 this small list of patients here, Ms. Newbury.
 17 MS. NEWBURY:
 18 Q. Okay, and there's a larger list which contains
 19 this information and some additional
 20 information at Exhibit P-2642, and this was
 21 from Heather Predham to Dr. Denic, and Dr.
 22 Laing was familiar with this as well, and
 23 attached - I wonder if we can reverse the
 24 orientation. There we go. Are you familiar
 25 with the information in this?

Page 107

1 MR. GULLIVER:
 2 A. I'm not, no.
 3 MS. NEWBURY:
 4 Q. Okay, and in terms of - you indicated that
 5 there were initially four retro converters
 6 that you were aware of, and you still think
 7 that there's a documented group of fewer than
 8 ten?
 9 MR. GULLIVER:
 10 A. That's to the best of my knowledge.
 11 MS. NEWBURY:
 12 Q. That's your best guesstimate.
 13 MR. GULLIVER:
 14 A. Yes.
 15 MS. NEWBURY:
 16 Q. You don't have a -
 17 MR. GULLIVER:
 18 A. I know it's not 50, 60, 70, or 100, you know,
 19 it's in that number range.
 20 MS. NEWBURY:
 21 Q. And how is retro converter defined in terms of
 22 coming up with that particular figure, the
 23 four or whatever figure now, less than 10
 24 percent?
 25 MR. GULLIVER:

Page 108

1 A. I don't - and I even hate the term "retro
 2 converter".
 3 MS. NEWBURY:
 4 Q. Okay.
 5 MR. GULLIVER:
 6 A. Whoever invented that term internally -
 7 MS. NEWBURY:
 8 Q. I think someone at Eastern Health can take
 9 credit for that.
 10 MR. GULLIVER:
 11 A. I know they did - as a retro converter, you
 12 know, a patient converted.
 13 MS. NEWBURY:
 14 Q. Right.
 15 MR. GULLIVER:
 16 A. Whether it was from positive to negative or
 17 negative to positive.
 18 MS. NEWBURY:
 19 Q. And I think the purpose was to try to
 20 distinguish.
 21 MR. GULLIVER:
 22 A. To try to distinguish that these are patients
 23 who originally -
 24 MS. NEWBURY:
 25 Q. For simplicity sake.

Page 109

1 MR. GULLIVER:
 2 A. Yeah.
 3 MS. NEWBURY:
 4 Q. I guess you can call it false positives as
 5 well.
 6 MR. GULLIVER:
 7 A. Yeah.
 8 MS. NEWBURY:
 9 Q. Do you know of that collection of four or
 10 whatever number it is less than ten now that
 11 it might be, would that include the results of
 12 a specimen for a deceased patient whose
 13 results changed?
 14 MR. GULLIVER:
 15 A. I'm assuming it would because we've had all
 16 the deceased patients now retested.
 17 MS. NEWBURY:
 18 Q. Okay, but in terms of the -
 19 MR. GULLIVER:
 20 A. But the original four, by that time we had not
 21 retested the deceased patients because the
 22 original four I knew by, I would say, sometime
 23 in '07, and I think those four were documented
 24 before the deceased patients were sent off for
 25 retesting.

Page 110

1 MS. NEWBURY:
 2 Q. It was Ms. Pilgrim's evidence just in the last
 3 couple of weeks, I think, late September,
 4 early October, that she's now aware of four
 5 retro converters. Are you - would that be
 6 something that's consistent with your
 7 understanding or not, based perhaps on new
 8 information about the results -
 9 MR. GULLIVER:
 10 A. I knew some time in '07, again through the
 11 other process.
 12 MS. NEWBURY:
 13 Q. Yeah. This has nothing to do with what you
 14 were doing on a day to day basis?
 15 MR. GULLIVER:
 16 A. Right.
 17 MS. NEWBURY:
 18 Q. Coming up with these figures.
 19 MR. GULLIVER:
 20 A. Right.
 21 MS. NEWBURY:
 22 Q. So you heard the number from someone?
 23 MR. GULLIVER:
 24 A. Yes.
 25 MS. NEWBURY:

Page 111

1 Q. But you don't know for sure how that number
 2 was derived by the person using the figure,
 3 whether they included the deceased patients or
 4 not?
 5 MR. GULLIVER:
 6 A. When I first heard the four, I heard it from
 7 somebody on the class action side of it, so I,
 8 you know -
 9 MS. NEWBURY:
 10 Q. Okay.
 11 MR. GULLIVER:
 12 A. But after that number is when we sent off the
 13 deceased patients for retesting.
 14 MS. NEWBURY:
 15 Q. So if the official number now is still four,
 16 do you know if that would include the results
 17 of deceased patients or not?
 18 MR. GULLIVER:
 19 A. I don't know if the official number - what the
 20 official number is.
 21 MS. NEWBURY:
 22 Q. And would the figure for the number of retro
 23 conversions of a test result include a
 24 situation where there was a change from a
 25 positive result to a negative result, but

Page 112

1 there was no recommended treatment change by a
 2 physician or the review panel?
 3 MR. GULLIVER:
 4 A. I wouldn't know that.
 5 MS. NEWBURY:
 6 Q. Okay, and do you know if a retro conversion
 7 would include a situation where you have an ER
 8 negative/PR positive test result, but upon
 9 retesting it was determined to be ER and PR
 10 negative, would that be included in the group
 11 of retro converters?
 12 MR. GULLIVER:
 13 A. I don't think so.
 14 MS. NEWBURY:
 15 Q. And why is that?
 16 MR. GULLIVER:
 17 A. Because I think the focus was more on the ER.
 18 MS. NEWBURY:
 19 Q. Okay. From your perspective, and keeping in
 20 mind that the oncologists involved are
 21 probably focused on trying to find out whether
 22 or not there should be a change of treatment
 23 for patients who are now living, but your
 24 perspective is different, I take it, as the
 25 director of the laboratory medicine program,

Page 113

1 you're dealing with the day to day events
 2 happening in the lab -
 3 MR. GULLIVER:
 4 A. You mean during '05?
 5 MS. NEWBURY:
 6 Q. Any time, 2005, 2006, 2007, today?
 7 MR. GULLIVER:
 8 A. My perspective is different how?
 9 MS. NEWBURY:
 10 Q. Your focus is broader, I would assume, than on
 11 just whether or not a living patient needs a
 12 change of treatment?
 13 MR. GULLIVER:
 14 A. I don't get what you want to ask me.
 15 MS. NEWBURY:
 16 Q. Let me ask the question another way. Would it
 17 be of interest to you that a specimen for a
 18 deceased patient changed from a positive
 19 result to a negative result?
 20 MR. GULLIVER:
 21 A. It certainly would be of interest to me, but I
 22 think it would be more important to the
 23 oncologist.
 24 MS. NEWBURY:
 25 Q. And why is it more important to the

Page 114

1 oncologist?
 2 MR. GULLIVER:
 3 A. Well, I think the oncologist would like to
 4 know that if they had a patient that they were
 5 treating for a various number of years, and
 6 now they discover that patient retested
 7 negative, you know, and that patient probably
 8 should not have been on hormone therapy.
 9 MS. NEWBURY:
 10 Q. And how about a retro conversion of a test
 11 result where ultimately there was no
 12 recommended treatment change by either a
 13 physician or the physician review panel. So
 14 there was a positive test result, say, 30/40
 15 and it changed to 0/0, but fortunately for
 16 whatever reason the patient had received the
 17 correct treatment from the outset based on the
 18 results being 0/0.
 19 MR. GULLIVER:
 20 A. So they didn't get hormone therapy?
 21 MS. NEWBURY:
 22 Q. Right. Is that of interest to you as the
 23 director of the laboratory medicine program?
 24 MR. GULLIVER:
 25 A. I think - yes, it would be.

Page 115

1 MS. NEWBURY:
 2 Q. Okay.
 3 MR. GULLIVER:
 4 A. Anybody involved in this.
 5 MS. NEWBURY:
 6 Q. And if a test result was originally ER
 7 negative and PR positive, but that converts to
 8 0/0, is that of interest to you as the
 9 director of the laboratory medicine program?
 10 MR. GULLIVER:
 11 A. Again anybody who's involved in this, those
 12 would be of interest to us, yes.
 13 MS. NEWBURY:
 14 Q. And your particular interest would be to do
 15 what? How is that of interest to you?
 16 MR. GULLIVER:
 17 A. Well, I think it's - through all this here, I
 18 think it's also an interest in to look at
 19 individual cases.
 20 MS. NEWBURY:
 21 Q. But in terms of assessing potential problem
 22 areas or quality areas in the laboratory
 23 medicine program, would it be of interest to
 24 you to gather up and add up the numbers into
 25 those categories?

Page 116

1 MR. GULLIVER:
 2 A. It would give us statistics, add up those
 3 categories, and compare them to what you would
 4 expect in the literature or expect in the
 5 world now.
 6 MS. NEWBURY:
 7 Q. Okay, and you've had no reason to date to
 8 compile such a list that would include retro
 9 conversions for deceased patients or patients
 10 -
 11 MR. GULLIVER:
 12 A. I haven't, no.
 13 MS. NEWBURY:
 14 Q. Do you have any plans to do that?
 15 MR. GULLIVER:
 16 A. I don't think I do individually, but I think
 17 that once this piece of the inquiry is over,
 18 you know, as you heard Ms. Pilgrim testify,
 19 Eastern Health, I think, will be able to start
 20 focusing on reviewing the events of the past
 21 three years.
 22 MS. NEWBURY:
 23 Q. Okay. Dr. Laing was asked about some
 24 information about retro conversions that were
 25 not on those two lists that I showed you, 1373

Page 117

1 and 2642, and the information is contained in
 2 a document P-0720. This is an e-mail. Again
 3 you did not - you're not named here as a
 4 recipient of the e-mail, and it is information
 5 that was provided to Mark Quinn following a
 6 request for information, access to information
 7 request, and it contains several - quite a
 8 number of pages of information by columns
 9 indicating the original ER, the original PR,
 10 the Mount Sinai ER, and the Mount Sinai PR.
 11 Are you generally familiar with the layout of
 12 this, the data contained -
 13 MR. GULLIVER:
 14 A. Not really, no, no.
 15 MS. NEWBURY:
 16 Q. Did you ever do a similar analysis of
 17 comparing the original test results, whether
 18 they were positive, negative, with the Mount
 19 Sinai test results?
 20 MR. GULLIVER:
 21 A. In -
 22 MS. NEWBURY:
 23 Q. In an organized fashion like this prior to the
 24 NLCHI involvement?
 25 MR. GULLIVER:

Page 118

1 A. Prior to NLCHI, no.
 2 MS. NEWBURY:
 3 Q. And why is that?
 4 MR. GULLIVER:
 5 A. I just didn't have time.
 6 MS. NEWBURY:
 7 Q. Did you think it was important and didn't have
 8 time?
 9 MR. GULLIVER:
 10 A. I knew that, you know, NLCHI was coming in, it
 11 started in July '07.
 12 MS. NEWBURY:
 13 Q. But prior to that, you had no knowledge that
 14 NLCHI would be involved until, I think,
 15 somewhere around June or July of 2007.
 16 MR. GULLIVER:
 17 A. Certainly prior to that time, I had interest
 18 in things like, well, of the totals that were
 19 retested, you know, how many - how many came
 20 back with a changed result. I would have
 21 interest in the origin of the original
 22 specimen.
 23 MS. NEWBURY:
 24 Q. Uh-hm.
 25 MR. GULLIVER:

Page 119

1 A. Was it a specimen that originated in St.
 2 Clare's, Health Sciences, Corner Brook. I
 3 would have interest in the total numbers that
 4 were sent off from the nine different
 5 pathology labs in the province. I would have
 6 interest in, you know, pathologists or groups
 7 of pathologists -
 8 MS. NEWBURY:
 9 Q. Right.
 10 MR. GULLIVER:
 11 A. Who may be interpreting them.
 12 MS. NEWBURY:
 13 Q. And year by year analysis, would that be of
 14 interest to you?
 15 MR. GULLIVER:
 16 A. Yes, it would be.
 17 MS. NEWBURY:
 18 Q. Yeah.
 19 MR. GULLIVER:
 20 A. But that's certainly something that by July
 21 '07, you know, we just did not have the time
 22 or the resources to be able to start doing
 23 that, and, you know, when NLCHI then was
 24 seconded and we knew that would be a piece of
 25 the outcome from NLCHI.

Page 120

1 MS. NEWBURY:
 2 Q. Did you ever express that view to anyone else
 3 that this will be a worthwhile exercise?
 4 MR. GULLIVER:
 5 A. I certainly have, yes.
 6 MS. NEWBURY:
 7 Q. And to whom did you express that?
 8 MR. GULLIVER:
 9 A. I think in general to again the same people
 10 that you've heard over and over who were
 11 actively involved in this here. Again they're
 12 all in the same boat that I was in, you know,
 13 you're doing this - this file along with the
 14 rest of your job. I think that it's something
 15 that Eastern Health had talked about, you
 16 know, talking about engaging, like, even
 17 researchers to do some kind of analysis and
 18 summary of all this here.
 19 MS. NEWBURY:
 20 Q. But even something less sophisticated than
 21 having perhaps statisticians or
 22 epidemiologists involved, just for your own
 23 review - you don't think you had any time just
 24 to add to your tables. You already had
 25 tables, I think, by year that you and Mr. Dyer

Page 121

1 prepared, just to add in the results for the
 2 Mount Sinai ER and PR?
 3 MR. GULLIVER:
 4 A. I know, but that would have meant reviewing
 5 another thousand patients and then reviewing
 6 them and putting them into specific
 7 categories. So it's a patient from Western
 8 Memorial, Gander, Grand Falls, Carbonear,
 9 Clarenville, Health Sciences, Grace, St.
 10 Clare's, St. Anthony. There would have been
 11 another table then which pathologist did the
 12 original interpretation, you know, the time
 13 frame that the testing was done, broken down
 14 by year, so it's -
 15 MS. NEWBURY:
 16 Q. Now a couple of those categories -
 17 MR. GULLIVER:
 18 A. It's a significant amount of work.
 19 MS. NEWBURY:
 20 Q. Yes, no doubt it will be, but a couple of
 21 those tables already existed by year and by
 22 region, isn't that correct?
 23 MR. GULLIVER:
 24 A. Not - only in numbers, but not broken down by
 25 patient results.

Page 122

1 MS. NEWBURY:
 2 Q. Okay, so you didn't have separate tables -
 3 MR. GULLIVER:
 4 A. No.
 5 MS. NEWBURY:
 6 Q. For sending off for retesting purposes? I had
 7 understood that that was -
 8 MR. GULLIVER:
 9 A. No, no, we had - for the regions, yes.
 10 MS. NEWBURY:
 11 Q. Yes, for the regions.
 12 MR. GULLIVER:
 13 A. Yes.
 14 MS. NEWBURY:
 15 Q. Okay, and how about St. John's, would you have
 16 -
 17 MR. GULLIVER:
 18 A. And for St. John's, they were for St. John's
 19 patients.
 20 MS. NEWBURY:
 21 Q. Okay, and that wasn't broken down by year, was
 22 it?
 23 MR. GULLIVER:
 24 A. It was broken down by year, and then you could
 25 go to the spreadsheet to see what the original

Page 123

1 site, like, where the patient had their
 2 primary surgery.
 3 MS. NEWBURY:
 4 Q. Okay, but at the very least you did have some
 5 tables, not as organized or sophisticated -
 6 MR. GULLIVER:
 7 A. Yes.
 8 MS. NEWBURY:
 9 Q. As having pathologists or sites in St. John's
 10 even, but you did have some tables there?
 11 MR. GULLIVER:
 12 A. Some.
 13 MS. NEWBURY:
 14 Q. Now, Mr. Gulliver, there's some information
 15 here on Exhibit 720 which is something that
 16 you're not familiar with, but I wanted to
 17 bring to your attention some results here, and
 18 line 20 has two entries, which I assume would
 19 be for the same patient, although I'm really
 20 not sure, and one of the results was a
 21 negative ER, 75 PR, and retesting it went to 2
 22 and 0, and I couldn't locate that on either P-
 23 2642 or 1373, which were the lists that Dr.
 24 Laing was aware of.
 25 MR. GULLIVER:

Page 124

1 A. Okay.
 2 MS. NEWBURY:
 3 Q. And would you have any explanation for why
 4 that would not be on her lists?
 5 MR. GULLIVER:
 6 A. No.
 7 MS. NEWBURY:
 8 Q. Were you even aware of this type of a result,
 9 this particular - did anyone ever bring to
 10 your attention, gee, this is unusual, we have
 11 a result that was negative for ER, 75 PR,
 12 and then it converted to 2 and 0?
 13 MR. GULLIVER:
 14 A. No.
 15 MS. NEWBURY:
 16 Q. No one ever brought that to your attention?
 17 MR. GULLIVER:
 18 A. No.
 19 MS. NEWBURY:
 20 Q. Line 61, we have a result - again there are
 21 several entries there, but the third line for
 22 61 -
 23 MR. GULLIVER:
 24 A. And I'm thinking - this must be the same
 25 patient retested more than once or more than

Page 125

1 one block, I'm assuming.
 2 MS. NEWBURY:
 3 Q. Yeah, unfortunately there's not - this was
 4 done for Mr. Quinn, so it's not as elaborate
 5 as having surgical numbers.
 6 MR. GULLIVER:
 7 A. Yeah.
 8 MS. NEWBURY:
 9 Q. Those types of information. So this is - or
 10 even whether this was done over several.
 11 Unfortunately, that information is not there,
 12 but the third line for 61, we've got a 0 ER,
 13 50/60 PR, 0 and 0, and I couldn't locate that
 14 on the table that Dr. Laing was working with.
 15 MR. GULLIVER:
 16 A. And again I wouldn't know.
 17 MS. NEWBURY:
 18 Q. And no one ever brought that to your
 19 attention?
 20 MR. GULLIVER:
 21 A. No.
 22 MS. NEWBURY:
 23 Q. Would that have been of interest to you?
 24 MR. GULLIVER:
 25 A. This particular case, or do you mean in

Page 126

1 general?
 2 MS. NEWBURY:
 3 Q. Just the very fact that you've got that
 4 conversion. I mean, you've indicated that it
 5 was your understanding that a conversion from
 6 a positive result to a negative result would
 7 be very rare. Was there ever any
 8 understanding that it would be different for
 9 PR?
 10 MR. GULLIVER:
 11 A. Well, and again I think, you know, we were
 12 told by the oncologists that the ER was the
 13 more critical one to focus on.
 14 MS. NEWBURY:
 15 Q. Do you know whether or not they would have
 16 treated a patient who was -
 17 MR. GULLIVER:
 18 A. I don't know that. I mean -
 19 MS. NEWBURY:
 20 Q. And just in terms of the - and again there is
 21 some evidence that they did, in fact, treat
 22 these patients as positive. That was a
 23 general practice.
 24 MR. GULLIVER:
 25 A. You mean if they were ER negative, PR

Page 127

1 positive?
 2 MS. NEWBURY:
 3 Q. Yes.
 4 MR. GULLIVER:
 5 A. I don't know if that was - I think you heard
 6 individual oncologists apply that differently.
 7 MS. NEWBURY:
 8 Q. I think the evidence of Dr. McCarthy, that was
 9 a prevalent practice, and she's been here,
 10 that she was aware of anyway. So certainly
 11 some did, if not all. And that was never ever
 12 brought to your attention at any time
 13 throughout this process or is that--did you
 14 just hear that for the first time after the
 15 Inquiry started?
 16 MR. GULLIVER:
 17 A. Hear what? That something was a zero ER and
 18 positive PR -
 19 MS. NEWBURY:
 20 Q. Yes.
 21 MR. GULLIVER:
 22 A. - and then was a zero, zero?
 23 MS. NEWBURY:
 24 Q. And then a patient who's a zero ER but a
 25 positive PR might be treated with hormone

Page 128

1 therapy?
 2 MR. GULLIVER:
 3 A. Oh no, I heard that before the Inquiry
 4 started.
 5 MS. NEWBURY:
 6 Q. Oh, okay. So you were aware of that.
 7 MR. GULLIVER:
 8 A. At some meeting where we were there with the
 9 oncologists.
 10 MS. NEWBURY:
 11 Q. Okay, I had misunderstood when you said that.
 12 MR. GULLIVER:
 13 A. I even heard--I heard Dr. Kwan say that people
 14 who were zero, zero, he treated them with
 15 hormone therapy. He looked at the clinical--
 16 the age of the woman, the clinical history.
 17 So he stated that early on.
 18 MS. NEWBURY:
 19 Q. Right, but did he make any comment about how
 20 common it was for oncologists to treat -
 21 MR. GULLIVER:
 22 A. He did not say that, no.
 23 MS. NEWBURY:
 24 Q. Okay. Would it concern you that you've got
 25 conversions? Like today, if you went into

Page 129

1 your lab and you were told by Mr. Dyer that
 2 "well, we've got this result." It was zero
 3 ER, 50-60 PR and the patient requested a
 4 retest or the pathologist or oncologist
 5 requested a repeat and now the results are
 6 zero, zero. What would you do if you
 7 encountered that?
 8 MR. GULLIVER:
 9 A. Would it concern me today?
 10 MS. NEWBURY:
 11 Q. Yes.
 12 MR. GULLIVER:
 13 A. Certainly would.
 14 MS. NEWBURY:
 15 Q. Okay, and would it have concerned you in 2005
 16 or 2006?
 17 MR. GULLIVER:
 18 A. Well, certainly it would, yes.
 19 MS. NEWBURY:
 20 Q. Okay, and do you know if anyone else within
 21 your lab would also be cognizant of that as a
 22 concern, Mr. Dyer or the other lab
 23 technologists?
 24 MR. GULLIVER:
 25 A. Well, I think Dr. Ford Elms, the director of

Page 130

1 the lab, would be the main concern.
 2 MS. NEWBURY:
 3 Q. Okay. So if you came across a result like
 4 that now, you would bring it to Dr. Elms'
 5 attention?
 6 MR. GULLIVER:
 7 A. Well, I wouldn't come across a result like
 8 that. I mean -
 9 MS. NEWBURY:
 10 Q. Well, what if you happened to, for some
 11 reason? If Mr. Dyer -
 12 MR. GULLIVER:
 13 A. Well, I would bring it to Dr. Denic, the
 14 clinical chief.
 15 MS. NEWBURY:
 16 Q. Okay, and he would bring it to Dr. Elms?
 17 MR. GULLIVER:
 18 A. Yes, or to Ford, either, whoever I could get
 19 hold of first.
 20 MS. NEWBURY:
 21 Q. Okay.
 22 MR. GULLIVER:
 23 A. Pretty well.
 24 MS. NEWBURY:
 25 Q. And there are a number of others, I'm not

Page 131

1 going to bring you through all of them. Now
 2 we have a result here, line 717, negative for
 3 ER, greater than 60 for PR and zero, zero for
 4 the Mount Sinai retest results.
 5 MR. GULLIVER:
 6 A. You know, and again, I mean, I haven't seen
 7 this here, in this--you know, like this here
 8 laid out.
 9 MS. NEWBURY:
 10 Q. Sure, and then we've got another one, line
 11 767, negative, 40-50 for PR and then zero,
 12 zero for ER and PR upon retesting, and 827,
 13 we've got one entry, negative for ER, 60-70
 14 for PR, and then we have zero and zero for
 15 retesting, and now these are separate and
 16 above from those that are acknowledged to be
 17 retro converters on the list that Dr. Laing
 18 had seen. So is this new information for you
 19 today? Did you have any idea that there is
 20 other information out there which suggests
 21 that there's been a retro conversion? And I
 22 don't think there's an explanation for that.
 23 MR. GULLIVER:
 24 A. I think they based the retro conversion based
 25 upon the negative ER.

Page 132

1 MS. NEWBURY:
 2 Q. Okay. So if there's a conversion from a PR
 3 result to a ER negative result -
 4 MR. GULLIVER:
 5 A. I don't think they call that a retro
 6 converter. I can't be 100 percent sure.
 7 Again, you know, Ms. Predham was involved with
 8 this here with the oncologists and you know,
 9 she would be the more accurate person to
 10 answer that.
 11 MS. NEWBURY:
 12 Q. And I believe if we go to--if we could bring
 13 up 1373 again, please? Now this list actually
 14 has a couple of instances there where there's
 15 a negative result for ER and a 50-60 for PR.
 16 So they do appear to be, and I think it's
 17 consistent with Dr. Laing's testimony, that
 18 that would be considered a retro converter.
 19 MR. GULLIVER:
 20 A. Again, I can't answer that question.
 21 MS. NEWBURY:
 22 Q. So there's no sort of--you're not on the same
 23 page here with the oncologists, are you?
 24 MR. GULLIVER:
 25 A. No.

Page 133

1 MS. NEWBURY:
 2 Q. In terms of what would be considered a retro
 3 converter?
 4 MR. GULLIVER:
 5 A. No.
 6 MS. NEWBURY:
 7 Q. And no one has ever brought to your attention
 8 that there's a potential issue here with PRs
 9 that are converting to zeros?
 10 MR. GULLIVER:
 11 A. No.
 12 THE COMMISSIONER:
 13 Q. Ms. Newbury, it's around the time for the
 14 morning break (inaudible).
 15 MS. NEWBURY:
 16 Q. Okay. Well, this is probably a good place to
 17 break.
 18 THE COMMISSIONER:
 19 Q. All right. We'll take the morning break.
 20 (BREAK)
 21 THE COMMISSIONER:
 22 Q. Please be seated. Ms. Newbury.
 23 MS. NEWBURY:
 24 Q. Mr. Gulliver, I just showed you a few entries
 25 in the data that was given to Mark Quinn at P-

Page 134

1 0720, please, and you indicated that those
 2 were--you noted that those were PR
 3 conversions. They weren't ER conversions, and
 4 perhaps that may have been a reason why it
 5 wasn't brought to your attention. Is that -
 6 MR. GULLIVER:
 7 A. Quite possible, yes.
 8 MS. NEWBURY:
 9 Q. Okay. There are some other retro conversions
 10 that are not on either of Dr. Laing's lists
 11 that she was familiar with, the two that I
 12 showed you just before the break. If we go to
 13 line 132 of Exhibit P-0720? We have an entry,
 14 line 132, original ER and PR ten and ten and
 15 Mount Sinai zero and zero, and there are
 16 several other similar entries. 239, we've got
 17 a ten ten and zero zero, and the same thing at
 18 line 413. Actually, there is a ten, ten and
 19 less than one and zero, upon retesting. And
 20 line 804, we have ten ten going to zero zero,
 21 line 804. Also, line 778, there's a 10 to 20
 22 for ER and 40 to 50 for PR and that converts
 23 to zero, zero. And line 520, there is a
 24 result 40 for ER, zero for PR and that
 25 converts to five and zero. And line 615,

Page 135

1 that's a 20 for ER, zero for PR and then zero,
 2 zero upon retesting at Mount Sinai, and then
 3 back at the beginning of the document, line
 4 68, we have a 20 ER, zero PR and that converts
 5 to zero, zero upon retesting at Mount Sinai.
 6 These numbers that I've just shown you,
 7 on the longer of the two exhibits that I
 8 showed to you this morning that Dr. Laing was
 9 familiar with, there was one instance of a
 10 ten, ten converting to zero, zero. There was
 11 only one instance of that, whereas in this
 12 document here, there are a total of four, and
 13 the other conversions that I just showed you,
 14 the 40, zero to five, zero, 10-20, 40-50 to
 15 zero, zero, 20 zero to zero, zero, two
 16 instances of those, they were not on the list
 17 that Dr. Laing had been shown and was familiar
 18 with.
 19 So there appears to be here, in addition
 20 to the PR retro conversions, a number of other
 21 ER retro conversions. That would be, you
 22 know, what you might glean from the numbers
 23 there, and are you familiar with all of these
 24 different instances of apparent retro
 25 conversions?

Page 136

1 MR. GULLIVER:
 2 A. Not individually, but I think first of all,
 3 you have to ask what were the oncologists and
 4 Ms. Predham's definition of a retro converter,
 5 and to my knowledge, they categorize people as
 6 a retro converter as people who had a
 7 treatment change in reverse.
 8 MS. NEWBURY:
 9 Q. Right, so they had been given hormone therapy
 10 and perhaps they ought not to have -
 11 MR. GULLIVER:
 12 A. Based upon the original test results, and what
 13 -
 14 MS. NEWBURY:
 15 Q. Now before the break--sorry, before the break,
 16 you weren't aware of that. I had asked you
 17 that question. Is that something that you
 18 learned in between or -
 19 MR. GULLIVER:
 20 A. You asked me what--sorry?
 21 MS. NEWBURY:
 22 Q. I had asked you if you understood what their
 23 definition was of retro conversion.
 24 MR. GULLIVER:
 25 A. I don't remember you asking me that question.

Page 137

1 MS. NEWBURY:
 2 Q. Okay. So is that something that just came to
 3 your mind then, that that's what they would
 4 have included as a retro conversion?
 5 MR. GULLIVER:
 6 A. To my knowledge, that's what they were--the
 7 retro conversions were based upon treatment,
 8 but all what you showed--what we're not seeing
 9 here though in this table, Ms. Newbury, is the
 10 ones that you're highlighting certainly on
 11 paper could look like it was ten and ten and
 12 came back zero and zero, and why was not that
 13 considered a retro converter. What we're
 14 missing here is the time frame of the original
 15 test. I'm assuming that most, as you've shown
 16 me, ten, ten, zero, zero, were probably done
 17 in the '97 to 2000 time frame where the
 18 treatment side was--it was less than 30 they
 19 considered as negative and didn't offer
 20 treatment. But on a retesting, it came back
 21 ten, ten, zero, zero, so it probably didn't
 22 effect a treatment change.
 23 MS. NEWBURY:
 24 Q. So that's a possible explanation, but do you
 25 actually know that that's the case?

Page 138

1 MR. GULLIVER:
 2 A. I can't tell you 100 percent, no, but I mean,
 3 that's from--you're asking me my opinion and
 4 that's the best opinion I can give you.
 5 MS. NEWBURY:
 6 Q. Okay, and it is your understanding that the
 7 treatment--whether or not there was a change
 8 of treatment is what would determine who would
 9 be placed on the list of retro conversions?
 10 MR. GULLIVER:
 11 A. To the best of my knowledge, yes.
 12 MS. NEWBURY:
 13 Q. Okay.
 14 MR. GULLIVER:
 15 A. Again, you know, Ms. Predham, who is up after
 16 me, would be probably the best person to ask
 17 that question.
 18 MS. NEWBURY:
 19 Q. From your own perspective, considering that
 20 you're the director of Laboratory Medicine,
 21 and recognizing that the standards have
 22 changed over the years, that a ten now is
 23 typically treated as positive--that's evidence
 24 that we've heard from any oncologist, in fact
 25 sometimes less than that--is it of interest to

Page 139

1 you to get to the root of that problem, to
 2 find out why are there conversions from ten to
 3 zero? Whether it's a zero ten to a zero, zero
 4 or a ten, ten to zero, zero.
 5 MR. GULLIVER:
 6 A. Well, again, I think you've heard it could be
 7 multiple factors that could be involved in a
 8 reason for a change like that.
 9 MS. NEWBURY:
 10 Q. Yes, and I'm wondering if you're interested in
 11 finding out what those multiple factors are in
 12 these particular instances.
 13 MR. GULLIVER:
 14 A. I'll have to say yes.
 15 MS. NEWBURY:
 16 Q. Okay, and given that Ms. Predham might have
 17 been focused on the actual treatment, in terms
 18 of her role there, do you see that your
 19 interest might be a little broader than that?
 20 Your interest might be more on what does this
 21 tell us mechanically about what's happening or
 22 technically in the lab from a day-to-day
 23 basis?
 24 MR. GULLIVER:
 25 A. Well, I think both technically and from a

Page 140

1 pathologist's perspective also. I mean, the
 2 lab is just not the pathologists or just the
 3 technologists. I mean, it's a group effort.
 4 MS. NEWBURY:
 5 Q. Okay, and in light of these various numbers
 6 that I've shown you and regardless of whether
 7 there's a change of treatment, from your
 8 perspective, would you still say that there
 9 are only four or fewer than ten retro
 10 conversions? Do you have any--has this cast
 11 any doubt on your conclusion about that?
 12 MR. GULLIVER:
 13 A. I don't think so. I think that, again, the
 14 best of my knowledge that there's been a few
 15 number of patients who were on hormone
 16 therapy. On retesting they had to come off
 17 hormone therapy.
 18 MS. NEWBURY:
 19 Q. Okay. So in your mind, not just in Ms.
 20 Predham's mind, but in your mind, if a person
 21 was not initially treated with hormone
 22 therapy, whether it was 1998 or 2002, even if
 23 their results ended up, upon retesting, being
 24 a zero, zero result, you do not consider that
 25 a retro conversion?

Page 141

1 MR. GULLIVER:
 2 A. So originally, what was the original result?
 3 MS. NEWBURY:
 4 Q. Well, I've shown you a number. You've got a
 5 negative ER, 40-50 PR.
 6 MR. GULLIVER:
 7 A. And that patient -
 8 MS. NEWBURY:
 9 Q. Going to zero, zero.
 10 MR. GULLIVER:
 11 A. And the patient was not treated, based upon
 12 that?
 13 MS. NEWBURY:
 14 Q. Well, I have no idea. I'm just wondering,
 15 from your perspective, would you consider that
 16 to be a retro conversion or would you need to
 17 know whether that person was initially treated
 18 or not?
 19 MR. GULLIVER:
 20 A. I think you'd need to know what the treatment
 21 was also.
 22 MS. NEWBURY:
 23 Q. And say if you have a 40 ER and a zero PR
 24 converting to five and zero.
 25 MR. GULLIVER:

Page 142

1 A. I would call that a retro converter, in my
 2 lingo. But then you'd need to know how the
 3 patient was affected by it.
 4 MS. NEWBURY:
 5 Q. Okay, and say a patient was determined to be
 6 ten ER and ten PR in 2004, which is well after
 7 the change in cut off, would you consider that
 8 to be a retro conversion or would you need to
 9 know whether or not there's been a change of
 10 treatment?
 11 MR. GULLIVER:
 12 A. In 2004, the patient was originally tested
 13 ten, ten and then retested zero, zero?
 14 MS. NEWBURY:
 15 Q. Converts to zero, zero, and I don't have any
 16 idea because I don't have information about
 17 when these were done, but say that happened.
 18 MR. GULLIVER:
 19 A. And I can't--I can't say at all because I
 20 don't have it either.
 21 MS. NEWBURY:
 22 Q. No, and you haven't compiled your own list of
 23 that?
 24 MR. GULLIVER:
 25 A. No, no.

Page 143

1 MS. NEWBURY:
 2 Q. Okay. But would you consider at ten, ten
 3 converting to zero, zero, if it happened in
 4 2004, as an example, after the change of cut
 5 off, would you consider that to be retro
 6 conversion?
 7 MR. GULLIVER:
 8 A. I would consider it to be a false positive.
 9 MS. NEWBURY:
 10 Q. A false positive, okay.
 11 MR. GULLIVER:
 12 A. Whether it affected a patient treatment, I
 13 wouldn't know.
 14 MS. NEWBURY:
 15 Q. Okay. So that's--those are two separate
 16 issues?
 17 MR. GULLIVER:
 18 A. Yeah.
 19 MS. NEWBURY:
 20 Q. So, and you've mentioned earlier that you
 21 don't like the term retro conversion. Let me
 22 ask this question. If all of those numbers--
 23 would you consider those to be all false
 24 positives, the ones that I showed you? I
 25 mean, just looking at the numbers. Perhaps

Page 144

1 there's a typographical error there, but if
 2 those numbers are accurate, would you consider
 3 those to be false positives?
 4 MR. GULLIVER:
 5 A. So you're saying the one that, for example,
 6 that you see number 70 or something, it was
 7 ten, ten and was zero, zero?
 8 MS. NEWBURY:
 9 Q. Ten, ten, zero, zero or -
 10 MR. GULLIVER:
 11 A. Would I consider it to be a false positive?
 12 MS. NEWBURY:
 13 Q. Yes.
 14 MR. GULLIVER:
 15 A. I would have to say yes.
 16 MS. NEWBURY:
 17 Q. Okay.
 18 MR. GULLIVER:
 19 A. But then, you'd need to know why was it -
 20 MS. NEWBURY:
 21 Q. I understand. I'm focusing, I guess, on your
 22 perspective. Whether or not it impacted a
 23 patient's treatment, that would be another
 24 issue.
 25 MR. GULLIVER:

Page 145

1 A. Right.
 2 MS. NEWBURY:
 3 Q. But I'm focusing on your role, running a lab,
 4 the director of lab -
 5 MR. GULLIVER:
 6 A. From a lab perspective, I would have to
 7 consider that to be a false positive.
 8 MS. NEWBURY:
 9 Q. Okay, and how about negative 75 and converting
 10 to two, zero? Would you consider that to be a
 11 false positive?
 12 MR. GULLIVER:
 13 A. Negative and 75 for PR?
 14 MS. NEWBURY:
 15 Q. Yes.
 16 MR. GULLIVER:
 17 A. And on retesting it's two percent?
 18 MS. NEWBURY:
 19 Q. And zero.
 20 MR. GULLIVER:
 21 A. And zero percent?
 22 MS. NEWBURY:
 23 Q. Yes.
 24 MR. GULLIVER:
 25 A. That would be--again, that's one of those grey

Page 146

1 ones.
 2 MS. NEWBURY:
 3 Q. Okay, and is that because the two is not zero?
 4 MR. GULLIVER:
 5 A. I don't know.
 6 MS. NEWBURY:
 7 Q. Okay.
 8 MR. GULLIVER:
 9 A. You know, two percent.
 10 MS. NEWBURY:
 11 Q. Okay. So zero ER and 50 to 60 PR converting
 12 to zero, zero?
 13 MR. GULLIVER:
 14 A. I would have to say it's a false positive.
 15 MS. NEWBURY:
 16 Q. False positive, okay. So perhaps there's a
 17 difference in terminology between what Ms.
 18 Predham is using and others are using.
 19 MR. GULLIVER:
 20 A. It could be, yeah.
 21 MS. NEWBURY:
 22 Q. Refer to retro conversion, you prefer the term
 23 false positive?
 24 MR. GULLIVER:
 25 A. Yes, yeah.

Page 147

1 MS. NEWBURY:
 2 Q. Okay. So looking at the two lists that Dr.
 3 Laing was familiar with, as well as the
 4 information that I read out to you this
 5 morning, there would appear to be a number of
 6 false positives there, and a greater number
 7 than for retro conversions.
 8 MR. GULLIVER:
 9 A. I would have to say yes.
 10 MS. NEWBURY:
 11 Q. Okay, and is that of any concern to you?
 12 MR. GULLIVER:
 13 A. I think it only--it becomes a concern when you
 14 know how is the patient affected or how is the
 15 treatment, based upon that.
 16 MS. NEWBURY:
 17 Q. Is it a concern that you're having such a high
 18 frequency of these false positives, from a
 19 technical perspective?
 20 MR. GULLIVER:
 21 A. Again, I have not yet seen a full review of
 22 all the testing to be able to tell us this was
 23 the number of cases that tested false
 24 positive.
 25 MS. NEWBURY:

Page 148

1 Q. Okay. So you can't rule out whether or not
 2 there is a concern, but you can't say there is
 3 one?
 4 MR. GULLIVER:
 5 A. I can't say that there is one or I can't say
 6 there is not one.
 7 MS. NEWBURY:
 8 Q. And that's primarily because you haven't
 9 actually seen the full list of false
 10 positives?
 11 MR. GULLIVER:
 12 A. Right.
 13 MS. NEWBURY:
 14 Q. Do you know if Dr. Denic would be aware of the
 15 number of false positives?
 16 MR. GULLIVER:
 17 A. I don't know.
 18 MS. NEWBURY:
 19 Q. And his evidence was that he had reviewed four
 20 slides that were from the retro converters and
 21 perhaps he was using the term in the same way
 22 that you were. Were you aware of Dr. Denic
 23 conducting a review of any other of these
 24 false positives that may not be--may not have
 25 had an impact on patient treatment?

Page 149

1 MR. GULLIVER:
 2 A. No, I'm not.
 3 MS. NEWBURY:
 4 Q. Okay. If Dr. Laing was not actually aware of
 5 the frequency of the false positives here, and
 6 if she were focusing, for example, on retro
 7 conversions or false positives that had an
 8 impact upon patient treatment, for example, of
 9 patients who were living as opposed to any
 10 deceased patients, would it be of concern to
 11 you that you're relying upon oncologists to
 12 say "oh, there's no concern with the positive
 13 test results"? That perhaps she didn't have a
 14 full picture of what was going on in the lab?
 15 MR. GULLIVER:
 16 A. Again, I don't know what Dr. Laing's full
 17 picture is or isn't.
 18 MS. NEWBURY:
 19 Q. Okay, and to this day, you don't know what her
 20 understanding was?
 21 MR. GULLIVER:
 22 A. No.
 23 MS. NEWBURY:
 24 Q. And is that of a concern to you, that you
 25 don't know what information Dr. Laing had?

Page 150

1 You're relying upon her to say whether there
 2 is or is not a concern, but you don't know
 3 what -
 4 MR. GULLIVER:
 5 A. I'm just relying upon her and her oncologists.
 6 MS. NEWBURY:
 7 Q. Right.
 8 MR. GULLIVER:
 9 A. And it's not just myself, it's the whole
 10 laboratory and Eastern Health, that you know,
 11 when the oncologists say that they don't have-
 12 -they have very little concern, no concern
 13 about the patients who originally tested
 14 positive, you know, I have to take them for
 15 their opinion.
 16 MS. NEWBURY:
 17 Q. Right, but when they did come across false
 18 positives for patients that were living, I
 19 believe it was her evidence that they would
 20 refer them to a panel and in some instances,
 21 if there was--if they have been treated with
 22 hormone therapy from the beginning, they would
 23 be taken off that hormone therapy. So it
 24 seems that that would be a concern if that
 25 were to occur?

Page 151

1 MR. GULLIVER:
 2 A. Yes.
 3 MS. NEWBURY:
 4 Q. Okay.
 5 MR. GULLIVER:
 6 A. And to date, as far as I know, again I'll tell
 7 you that to verify that, you know, those
 8 numbers have been very, very small.
 9 MS. NEWBURY:
 10 Q. Right, but you don't know though how many
 11 numbers of false positives there are in total
 12 and how many of them have been reviewed by the
 13 oncologists? I mean, Dr. Laing, I've showed
 14 you -
 15 MR. GULLIVER:
 16 A. I don't know the full total number, no.
 17 MS. NEWBURY:
 18 Q. Right, and I've showed you a number of bits of
 19 data that Dr. Laing wasn't familiar with. She
 20 was familiar with two lists of retro
 21 converters and she had some recollection of
 22 having some of those panelled, but she wasn't
 23 able to explain a number of these other
 24 entries from Exhibit P-0720.
 25 MR. GULLIVER:

Page 152

1 A. And I can't explain them either.
 2 MS. NEWBURY:
 3 Q. Mr. Gulliver, in your e-mail to Reza on July
 4 24th, 2007, in which you summarize the
 5 guidelines and the process used to select
 6 patients for retesting, you stated at the end
 7 of the document--I could bring this up for
 8 your information, P-2129 please? Okay, this
 9 is the document. I think you were shown this
 10 yesterday. It's July 24th, 2007, and I wanted
 11 to refer you to the end of the document here,
 12 item ten, and then the last paragraph. It
 13 states that "once results started to come
 14 back, they were reviewed by our pathologists
 15 and then the new results from Mount Sinai were
 16 added to the patient's original report in our
 17 LIS Meditech system, and a new report
 18 generated with both the original and new
 19 results. Barry and I had very little
 20 involvement after results came back. The
 21 pathologists, oncologists, QI department,
 22 communications department, handles this phase
 23 of the process."
 24 Mr. Gulliver, was that division of duties
 25 and I guess your lack of involvement after the

Page 153

1 results came back, was that something that
 2 was, you know, by design? Was there a meeting
 3 to discuss the allocation of who does what
 4 when the results come back?
 5 MR. GULLIVER:
 6 A. I don't think there was a--there was no
 7 meeting. I think it just evolved.
 8 MS. NEWBURY:
 9 Q. Okay.
 10 MR. GULLIVER:
 11 A. Again, what I'm indicating there, once the
 12 results came back and were verified, the
 13 laboratory's responsibility, particularly mine
 14 and Mr. Dyer's and the staff, was to ensure
 15 that the new results were put into the
 16 computer system so it's documented and
 17 recorded. The last piece here for Reza is
 18 talking about then the implications of those
 19 new results. That was dealt with by those
 20 people, either the oncologists in speaking to
 21 patients or assessing treatment or the QI
 22 department, communications in the patient
 23 disclosure, contacting patients and that whole
 24 piece of it.
 25 MS. NEWBURY:

Page 154

1 Q. And so in terms of the mechanics of you, of
 2 entering the results into the LIS Meditech
 3 system, who did that? Who sat down at the
 4 system and -
 5 MR. GULLIVER:
 6 A. Most often, early on, mostly it was Dr. Cook's
 7 secretary.
 8 MS. NEWBURY:
 9 Q. Okay.
 10 MR. GULLIVER:
 11 A. Who would input information. I know Mr. Dyer
 12 did some. I know Mary Butler, the senior
 13 tech, that was part of her role to ensure that
 14 new results would go into the computer system,
 15 that a new number was created to document
 16 receiving back from Mount Sinai and that
 17 reports were printed off by the secretary and
 18 then, you know, distributed.
 19 MS. NEWBURY:
 20 Q. So there's a combination of people involved
 21 with that?
 22 MR. GULLIVER:
 23 A. A combination, yes.
 24 MS. NEWBURY:
 25 Q. Was there any thought given to asking that

Page 155

1 person to also, aside from entering it into
 2 the Meditech system, adding it to the tables
 3 that you and Mr. Dyer had?
 4 MR. GULLIVER:
 5 A. No.
 6 MS. NEWBURY:
 7 Q. And why not?
 8 MR. GULLIVER:
 9 A. Well, what would enter in the table would be
 10 the actual results.
 11 MS. NEWBURY:
 12 Q. Yes.
 13 MR. GULLIVER:
 14 A. New results.
 15 MS. NEWBURY:
 16 Q. Yes.
 17 MR. GULLIVER:
 18 A. Dr. Cook was doing that piece of it. He was
 19 adding the results to -
 20 MS. NEWBURY:
 21 Q. To the Meditech?
 22 MR. GULLIVER:
 23 A. No, he was adding results to the spreadsheets,
 24 so he would know here are the results of the
 25 patients and he was tracking that there in

Page 156

1 conjunction with Heather Predham.
 2 MS. NEWBURY:
 3 Q. Okay, and was that side by side with the
 4 original results?
 5 MR. GULLIVER:
 6 A. In most cases, as far as I know, yes.
 7 MS. NEWBURY:
 8 Q. Okay, and have you seen those results?
 9 MR. GULLIVER:
 10 A. I have not seen a full list of them, no.
 11 MS. NEWBURY:
 12 Q. Okay, and is there any reason why you haven't?
 13 MR. GULLIVER:
 14 A. Nothing in particular.
 15 MS. NEWBURY:
 16 Q. Okay, and -
 17 MR. GULLIVER:
 18 A. That's been--was handled by the clinical side.
 19 MS. NEWBURY:
 20 Q. And what format was Dr. Cook using for those
 21 tables?
 22 MR. GULLIVER:
 23 A. The spreadsheets which I've shown that I've
 24 created.
 25 MS. NEWBURY:

Page 157

1 Q. Okay, that you provided to him.
 2 MR. GULLIVER:
 3 A. They were copied and he had a copy of those,
 4 and there was a place on those spreadsheets
 5 left for the results from Mount Sinai to be
 6 entered in there.
 7 MS. NEWBURY:
 8 Q. Okay, and it's your understanding that those
 9 were all completed, were they?
 10 MR. GULLIVER:
 11 A. To the best of my knowledge.
 12 MS. NEWBURY:
 13 Q. Okay, and so earlier today, I was trying to
 14 find out if there had been a comparison done
 15 of the original and the Mount Sinai test
 16 results, and you thought it would be
 17 interesting to do, to have some information to
 18 look for trends perhaps in the years or the
 19 pathologists.
 20 MR. GULLIVER:
 21 A. But those spreadsheets doesn't have complete
 22 information.
 23 MS. NEWBURY:
 24 Q. No, what does it have?
 25 MR. GULLIVER:

Page 158

1 A. Again, you've seen them. It has the basis
 2 patient demographic. It has the original
 3 result and that's all I had.
 4 MS. NEWBURY:
 5 Q. Okay. So it's not broken down by year?
 6 MR. GULLIVER:
 7 A. No.
 8 MS. NEWBURY:
 9 Q. And you had some other sheets broken down by
 10 year and by region.
 11 MR. GULLIVER:
 12 A. No, no, the spreadsheets are broken down by
 13 year.
 14 MS. NEWBURY:
 15 Q. Okay.
 16 MR. GULLIVER:
 17 A. But then on those spreadsheets, there is not
 18 documentation, complete documentation of what
 19 block was originally tested, what block was
 20 retested. You know, so it's not a complete--
 21 it's not complete enough to do a full set of
 22 data analysis of them. I think we're at that
 23 point now with, you know, NLCHI being
 24 involved, that those are the kinds of things
 25 that we can now perform.

Page 159

1 MS. NEWBURY:
 2 Q. And you never thought to ask Dr. Cook to have
 3 access to at least the incomplete documents
 4 that he had, just for some--to see if you can
 5 glean anything from that, for your
 6 perspective?
 7 MR. GULLIVER:
 8 A. No.
 9 MS. NEWBURY:
 10 Q. Now Mr. Gulliver, as a program director for
 11 the laboratory medicine program, was there an
 12 opportunity for you to have input into
 13 decisions by Eastern Health about the
 14 retesting plan for the ER and PR issues,
 15 particularly as they might relate to the
 16 laboratory medicine program?
 17 MR. GULLIVER:
 18 A. I would say yes.
 19 MS. NEWBURY:
 20 Q. Okay. Were there ever any limits placed upon
 21 your participation or your input?
 22 MR. GULLIVER:
 23 A. I don't think I've seen a list of things that
 24 I can't do. I think we all accepted here's
 25 the piece of it that, you know, that I can

Page 160

1 help with or that I can do.
 2 MS. NEWBURY:
 3 Q. And so no one ever said, well, this is going
 4 to be your role and only your role and don't
 5 stray from that? You could have, if you
 6 wanted to, for example, suggest looking at PR
 7 retro conversions or doing an analysis of the
 8 results to compare, you know, what happened by
 9 pathologists or breaking down by pathologists
 10 or regions?
 11 MR. GULLIVER:
 12 A. But I think we're only at that point now that
 13 we can do that.
 14 MS. NEWBURY:
 15 Q. Okay, and is that something that you'd ever
 16 suggested before?
 17 MR. GULLIVER:
 18 A. Again, as I said to you earlier, that before
 19 NLCHI got involved, those are some of the
 20 basic things that we did talk about and some
 21 of the things that we could look back and
 22 review, and you know, who would we get to do
 23 this kind of analysis and kind of review and
 24 before, I think, there was any kind of
 25 decision made, you know, NLCHI then got

Page 161

1 involved and we all felt that once that
 2 exercise was completed, that Eastern Health
 3 would now be in a position to do some data
 4 analysis.
 5 MS. NEWBURY:
 6 Q. Okay, and is it your understanding that
 7 Eastern Health would intend to look at the
 8 retro conversions, whether they're PR retro
 9 conversions or retro conversions for deceased
 10 patients?
 11 MR. GULLIVER:
 12 A. I just think that they would look at retro
 13 conversions.
 14 MS. NEWBURY:
 15 Q. But retro conversions by Ms. Predham's
 16 definition or retro conversions or false
 17 positives?
 18 MR. GULLIVER:
 19 A. I don't know. I think that we would have to
 20 do both. In my opinion -
 21 MS. NEWBURY:
 22 Q. That's your opinion.
 23 MR. GULLIVER:
 24 A. - I think if the retro converters are being
 25 classified as that because they had a

Page 162

1 treatment change, that that's one piece, and I
 2 think I would be more interested in looking at
 3 a false positive rate.
 4 MS. NEWBURY:
 5 Q. Have you ever expressed that opinion to anyone
 6 before, within Eastern Health?
 7 MR. GULLIVER:
 8 A. I would say yes, yeah.
 9 MS. NEWBURY:
 10 Q. And do you know who and when?
 11 MR. GULLIVER:
 12 A. I don't know when. I think some of these
 13 things are, you know, we discuss on a regular
 14 basis. On a weekly basis, we have, you know,
 15 what we call our ER/PR meeting. Those kinds
 16 of things would come up.
 17 MS. NEWBURY:
 18 Q. Okay. Just a couple of documents I wanted to
 19 ask you to explain, if you can. P-3107,
 20 please? Okay, this is a document sent by you
 21 to Ms. Predham, January 28th, 2008, so earlier
 22 this year, and it attaches some ER/PR
 23 statistics, and in the top two headings there,
 24 you've got a heading for DAKO and a heading
 25 for Ventana. So would it be correct to assume

Page 163

1 that the information in this table here would
 2 be the rates prior to any retesting at Mount
 3 Sinai?
 4 MR. GULLIVER:
 5 A. Oh yes.
 6 MS. NEWBURY:
 7 Q. Okay, these haven't been readjusted?
 8 MR. GULLIVER:
 9 A. No.
 10 MS. NEWBURY:
 11 Q. Okay.
 12 MR. GULLIVER:
 13 A. This is an exercise that confirmed with Reza
 14 through NLCHI in all parts of this whole ER/PR
 15 testing to kind of finalize those numbers.
 16 MS. NEWBURY:
 17 Q. Okay, and has tried to make sure that the data
 18 is accurate essentially?
 19 MR. GULLIVER:
 20 A. Yeah.
 21 MS. NEWBURY:
 22 Q. Okay, and does this include only the non--does
 23 this include any non-breast primaries?
 24 MR. GULLIVER:
 25 A. I can't say 100 percent, but it's pretty well

Page 164

1 part of our exercise was to make sure we
 2 removed any of those non-breast primaries.
 3 MS. NEWBURY:
 4 Q. Okay. So the intention was not to include non-
 5 breast primaries in this table?
 6 MR. GULLIVER:
 7 A. Exactly, yeah.
 8 MS. NEWBURY:
 9 Q. And in this table, there's references to
 10 positive negative rates and got several
 11 categories here on the left-hand side, the
 12 left-hand column. When you're talking about
 13 positive here, are you referring to ER only?
 14 So would that include ER positive, PR
 15 positive, ER negative, PR--or ER positive, PR
 16 negative?
 17 MR. GULLIVER:
 18 A. If it--say it again.
 19 MS. NEWBURY:
 20 Q. Let's put it this way, if you had an ER
 21 negative, PR positive test -
 22 MR. GULLIVER:
 23 A. I would call that a weak positive.
 24 MS. NEWBURY:
 25 Q. That would be called a weak positive.

Page 165

1 MR. GULLIVER:
 2 A. In that category, yes.
 3 MS. NEWBURY:
 4 Q. So that would all be -
 5 MR. GULLIVER:
 6 A. The ones where you see strong positive, all
 7 those would be a positive result for both ER
 8 and PR. The weak positives may have had, you
 9 know, a low positive for ER and it could be
 10 five percent ER, 90 percent PR. I would call
 11 that a weak positive.
 12 MS. NEWBURY:
 13 Q. Say you had, and I'll refer to a couple of the
 14 examples that I showed you earlier, a negative
 15 ER and a 40-50 PR or a negative ER and a 60-70
 16 PR?
 17 MR. GULLIVER:
 18 A. That would be weak positive.
 19 MS. NEWBURY:
 20 Q. Okay. So even if the PR is quite high, if the
 21 ER is negative, you call it a weak -
 22 MR. GULLIVER:
 23 A. Right.
 24 MS. NEWBURY:
 25 Q. Okay, thank you.

Page 166

1 MR. GULLIVER:
 2 A. Again, and this is just for an overview and
 3 assessment from a lab perspective that, you
 4 know, what percentage of cases had some degree
 5 of positivity reported on them.
 6 MS. NEWBURY:
 7 Q. Okay, and when you talk generally about your
 8 positivity rates, you've mentioned that you
 9 were interested in finding out what the
 10 positivity rates are for year to year, so that
 11 positivity rate would include ER negatives, PR
 12 positives?
 13 MR. GULLIVER:
 14 A. Yes.
 15 MS. NEWBURY:
 16 Q. Because you had categorized them as weak
 17 positives?
 18 MR. GULLIVER:
 19 A. Right.
 20 MS. NEWBURY:
 21 Q. Okay. Have you ever prepared a similar table
 22 that has the adjusted positivity rates?
 23 MR. GULLIVER:
 24 A. No.
 25 MS. NEWBURY:

Page 167

1 Q. And looking at the results there for 2004, you
 2 have a positivity rate of 89 percent and then
 3 that's for the DAKO machine, so -
 4 MR. GULLIVER:
 5 A. Again, but that's just--that's for three
 6 months.
 7 MS. NEWBURY:
 8 Q. Right.
 9 MR. GULLIVER:
 10 A. January, February, March.
 11 MS. NEWBURY:
 12 Q. So it's a small sample size.
 13 MR. GULLIVER:
 14 A. Very small sample size.
 15 MS. NEWBURY:
 16 Q. And then you have the Ventana, you have 86 for
 17 all three or for two of those periods of time.
 18 So April 4th to March 5th, 2005.
 19 MR. GULLIVER:
 20 A. That's for like a year and three or four
 21 months under Ventana.
 22 MS. NEWBURY:
 23 Q. Okay. So it's 86 percent for those two years?
 24 MR. GULLIVER:
 25 A. And again, it's still not--still, I mean,

Page 168

1 that's one of the things too that we had
 2 talked about with doing all this exercise is
 3 that, you know, when you have such a small
 4 sample size, you know, five or six or seven or
 5 eight patients one way or the other, it could
 6 make a big difference in your percentages.
 7 MS. NEWBURY:
 8 Q. Sure. Do you have any idea how many would be
 9 in say that period, April '04 to March '05?
 10 MR. GULLIVER:
 11 A. April, it tells you right here.
 12 MS. NEWBURY:
 13 Q. It's 119 at--okay, 119. So you consider that
 14 too small -
 15 MR. GULLIVER:
 16 A. There's 139 with results. So the percentages
 17 you see below are based upon the ones we have
 18 documented results that we know we can
 19 categorize them as positive or negative, weak
 20 positive. So the sample size there was 139.
 21 MS. NEWBURY:
 22 Q. Oh yes, I see, it's a third.
 23 MR. GULLIVER:
 24 A. The total Ventana is 198.
 25 MS. NEWBURY:

Page 169

1 Q. Okay.
 2 MR. GULLIVER:
 3 A. So when you see a positivity rate of 86
 4 percent on 198, again, you change five or six
 5 patients and it could drop down to 80 percent.
 6 MS. NEWBURY:
 7 Q. Now 189 is a bit of a larger sample size
 8 though than some of the others, like the 42
 9 for 2004 on DAKO is pretty small.
 10 MR. GULLIVER:
 11 A. And that's for the first three--the last three
 12 months of DAKO.
 13 MS. NEWBURY:
 14 Q. Until the Ventana was put in.
 15 MR. GULLIVER:
 16 A. First three months of the year, yes. But even
 17 if you see anything in any kind of like
 18 surveys, you know, really a sample size less
 19 than 400 is something that really could have a
 20 significant plus or minus.
 21 MS. NEWBURY:
 22 Q. So looking here though at the total test
 23 performed for each of those years, they're all
 24 less than 400.

Page 170

1 MR. GULLIVER:
 2 A. With results.
 3 MS. NEWBURY:
 4 Q. With results. So are you saying that there's
 5 no information -
 6 MR. GULLIVER:
 7 A. With results, I mean, I don't know the numbers
 8 of positives and weak positive negatives that
 9 were interpreted outside St. John's. These
 10 are strictly for St. John's numbers.
 11 MS. NEWBURY:
 12 Q. Right, so the only information you have is
 13 about what happened in St. John's?
 14 MR. GULLIVER:
 15 A. Right.
 16 MS. NEWBURY:
 17 Q. But are you concerned though that they're all
 18 under 400, in terms of sample size?
 19 MR. GULLIVER:
 20 A. Well I think then that's why on the bottom you
 21 do sort of a total test with results that you
 22 look at, you know, the whole big picture.
 23 There are 1,529 St. John's patients with
 24 results documented and of that total, there
 25 were 77 percent reported with positive

Page 171

1 staining and 23 percent that were reported
 2 with negative staining.
 3 MS. NEWBURY:
 4 Q. But do you think there's any value in looking
 5 at this year by year? I guess the question is
 6 if you found a particularly high or a
 7 particularly low rate for positivity in any
 8 given year, you had a small sample size in any
 9 given year -
 10 MR. GULLIVER:
 11 A. Well, I can--I mentioned this the other day.
 12 If you look at this table and the two years
 13 that really would look at--well, accepting it
 14 at face value, the two years that you would
 15 look in here would be 2000 and 2002.
 16 MS. NEWBURY:
 17 Q. And that's because there are 68 and 70 -
 18 MR. GULLIVER:
 19 A. And you look at there, that's the highest
 20 years that we have the highest percentage of
 21 negatives, of zero, zeros.
 22 MS. NEWBURY:
 23 Q. Right, but do you still see value in looking
 24 at that on a year-by-year basis,
 25 notwithstanding your small sample size?

Page 172

1 MR. GULLIVER:
 2 A. I think so, yes.
 3 MS. NEWBURY:
 4 Q. Okay, and looking at the Ventana results, and
 5 even the result for 2004, even though it's a
 6 small sample size, would that have to be
 7 adjusted to take into account your Mount Sinai
 8 retest results?
 9 MR. GULLIVER:
 10 A. Well, there's no retest results added in here.
 11 MS. NEWBURY:
 12 Q. No, I know, but if you were to look at--now to
 13 look back on what was your real positivity
 14 rate, would you not have to adjust it to take
 15 into account what happened at Mount Sinai?
 16 MR. GULLIVER:
 17 A. That has not been done.
 18 MS. NEWBURY:
 19 Q. Okay.
 20 MR. GULLIVER:
 21 A. But however, I mean, if you're asking so for
 22 example, if you're talking about the first
 23 three months of 2004?
 24 MS. NEWBURY:
 25 Q. Yes, just looking at the Ventana years, for

Page 173

1 example, you've got--that's a fairly large
 2 sample size.
 3 MR. GULLIVER:
 4 A. Okay, and again, I mean, for the years under
 5 Ventana, you know, and the ones that were
 6 retested were all the negatives, as you're
 7 well aware.
 8 MS. NEWBURY:
 9 Q. Right.
 10 MR. GULLIVER:
 11 A. So here, for the total for Ventana, during
 12 that time frame, there are 28 samples that
 13 were tested as negative, negative and I don't
 14 think any of them were converted.
 15 MS. NEWBURY:
 16 Q. But the information here would be with regard
 17 to all of the results that were done for that
 18 particular year?
 19 MR. GULLIVER:
 20 A. For the year. So for Ventana, the statistic
 21 wouldn't change because there are--we didn't
 22 have any confirmed conversions of a negative,
 23 negative Ventana and remained positive at
 24 Mount Sinai.
 25 MS. NEWBURY:

Page 174

1 Q. There were no conversions?
 2 MR. GULLIVER:
 3 A. No.
 4 MS. NEWBURY:
 5 Q. Okay, and is that the same for 2005?
 6 MR. GULLIVER:
 7 A. Well, the Ventana is all 2005, for all of
 8 Ventana.
 9 MS. NEWBURY:
 10 Q. You've got two different periods of time here,
 11 sorry.
 12 MR. GULLIVER:
 13 A. From April '04, because see, when I first did
 14 this here, it was the fiscal year up to April
 15 '04 to March '05 when we stopped--stopped
 16 DAKO, I did a full year of Ventana, get a full
 17 year statistics. Then I added on April, March
 18 (sic), June, July when we stopped testing.
 19 MS. NEWBURY:
 20 Q. Okay.
 21 MR. GULLIVER:
 22 A. But for the Ventana period -
 23 MS. NEWBURY:
 24 Q. The entire period, from April 2004 to July
 25 31st 2005, there was not -

Page 175

1 MR. GULLIVER:
 2 A. Right, to my knowledge, from what I've seen -
 3 MS. NEWBURY:
 4 Q. - there was not one single conversion?
 5 MR. GULLIVER:
 6 A. - we haven't seen one conversion from the
 7 Ventana.
 8 MS. NEWBURY:
 9 Q. Okay. So you wouldn't then have to adjust
 10 your positivity rate then?
 11 MR. GULLIVER:
 12 A. No.
 13 MS. NEWBURY:
 14 Q. There's no data that would suggest that?
 15 MR. GULLIVER:
 16 A. No.
 17 MS. NEWBURY:
 18 Q. Okay, and -
 19 MR. GULLIVER:
 20 A. And if it went back to '97, you know, the
 21 numbers of negatives that were retested that
 22 converted to--you know, came back as a
 23 positive, again, it was a very low number, so
 24 it wouldn't--the positivity rate may go up
 25 three or four percent in '97.

Page 176

1 MS. NEWBURY:
 2 Q. One more document, just if you can briefly
 3 explain what it is, P-3215, please? I'm not
 4 sure if you're familiar with this particular
 5 document. You're not a recipient here of the
 6 document. It was sent from Deborah Gregory to
 7 Paula Dillon and copied to Pat Pilgrim, is one
 8 of the people, what she received. And this is
 9 a draft document for internal review purposes
 10 only, and I believe this was prepared by
 11 NLCHI, and given that you were having some
 12 interaction with NLCHI in terms of getting the
 13 data together, would you be able to comment on
 14 what this particular table is about? Is this
 15 something that you're familiar with?
 16 MR. GULLIVER:
 17 A. Well, I mean, again, I mean I can't give you--
 18 I think NLCHI people are going to come and
 19 testify.
 20 MS. NEWBURY:
 21 Q. Okay, so you don't have any--you can't speak
 22 to this at all?
 23 MR. GULLIVER:
 24 A. Well, I mean, because this is just one table.
 25 There's multiple tables.

Page 177

1 MS. NEWBURY:
 2 Q. Sure, okay.
 3 MR. GULLIVER:
 4 A. And again, when you go through them, they're
 5 doing analysis based upon if something was one
 6 percent staining positive, if that was
 7 considered a positive, or ten percent or
 8 higher or 30 percent or higher.
 9 MS. NEWBURY:
 10 Q. Okay. Thank you, Mr. Gulliver. Those are all
 11 the questions.
 12 MR. GULLIVER:
 13 A. You're welcome.
 14 THE COMMISSIONER:
 15 Q. Mr. Crosbie.
 16 MR. TERRY GULLIVER, EXAMINATION BY CHESLEY CROSBIE, Q.C.
 17 CROSBIE, Q.C.:
 18 Q. One moment, Commissioner, figure out a way to
 19 re-rig so that I can see my notes better. It
 20 may work for Ms. Chaytor very well, but not
 21 for me.
 22 THE COMMISSIONER:
 23 Q. I learned long ago not to comment on Ms.
 24 Chaytor's size, Mr. Coffey. It's a very
 25 dangerous thing to do.

Page 178

1 CROSBIE, Q.C.:
 2 Q. Well, it seems to work for Mr. Coffey as well,
 3 but not for me.
 4 THE COMMISSIONER:
 5 Q. Okay.
 6 CROSBIE, Q.C.:
 7 Q. Thanks, Mr. Gulliver. We've met before, and
 8 as you know, I'm the class counsel for members
 9 of the Breast Cancer Testing Class Action and
 10 we have standing here. I'd like to take a
 11 step back, a step back to 1997, and just look
 12 at the overall setting at that time when the
 13 decision was being taken to establish ER/PR
 14 testing in a different section of the lab than
 15 it had been done before, and what I'm
 16 referring to there, I guess, is the fact that
 17 there was a technique called enzyme immuno
 18 assay or EIA which was conducted in the
 19 biochemistry section of the lab for the
 20 detection of positive ER and PR status in
 21 cancer patients. Am I correct so far?
 22 MR. GULLIVER:
 23 A. Yes, that's correct.
 24 CROSBIE, Q.C.:
 25 Q. And this technique involved taking fresh

Page 179

1 frozen - frozen tissue, and creating an
 2 emulsion out of it and using equipment, I
 3 won't try to describe because I don't
 4 understand, to get a count on the presence of
 5 positive staining in this emulsion, is that
 6 roughly true as well?
 7 MR. GULLIVER:
 8 A. I think, or the amount of estrogen in the
 9 emulsion.
 10 CROSBIE, Q.C.:
 11 Q. Uh-hm.
 12 MR. GULLIVER:
 13 A. It's not a staining then, it's a measurement.
 14 CROSBIE, Q.C.:
 15 Q. Okay. Now again this was conducted in - this
 16 was a biochemical procedure and it wasn't done
 17 in histology?
 18 MR. GULLIVER:
 19 A. Correct.
 20 CROSBIE, Q.C.:
 21 Q. It was done in biochemistry, whereas in
 22 histology there was at that time, 1997, and
 23 had been for a number of years going back to
 24 the 80s, I believe, tumours were being
 25 assessed or tested for staining purposes, and

Page 180

1 the results of that were being used by
 2 pathologists to refine their diagnoses, and
 3 these tumours might be lung, they might be
 4 brain, they might be other things. That's
 5 roughly correct again?
 6 MR. GULLIVER:
 7 A. For the IHC testing at that time?
 8 CROSBIE, Q.C.:
 9 Q. IHC testing was done -
 10 MR. GULLIVER:
 11 A. Yes.
 12 CROSBIE, Q.C.:
 13 Q. In histology for a number of years.
 14 MR. GULLIVER:
 15 A. Yes.
 16 CROSBIE, Q.C.:
 17 Q. This again being in 1997. So that if we
 18 contrast it to the - as I understand it now,
 19 the pathologists had nothing to do with the
 20 enzyme immuno assay testing performed over in
 21 the chemistry section, they weren't involved
 22 in signing out reports or interpreting the
 23 results of that testing at all, is that
 24 correct?
 25 MR. GULLIVER:

Page 181

1 A. They didn't interpret the result, but again, I
 2 mean, that patient who would have had a sample
 3 of a tumour submitted to biochemistry, then
 4 would have had their primary breast surgery
 5 done and the pathologist would have then seen
 6 the patient's tissue after the biochemical
 7 assay was performed, but they were not
 8 involved in interpreting the assay in
 9 biochemistry.
 10 CROSBIE, Q.C.:
 11 Q. Right, but they did do, of course, their usual
 12 histological diagnosis?
 13 MR. GULLIVER:
 14 A. Yes.
 15 CROSBIE, Q.C.:
 16 Q. However, in terms of the assay, they weren't
 17 involved in the interpretation of reporting of
 18 that?
 19 MR. GULLIVER:
 20 A. Not to my knowledge, no.
 21 CROSBIE, Q.C.:
 22 Q. Yeah, they had nothing to do with that per se.
 23 That was done for the benefit, well, of the
 24 patient, but for the oncologist who is
 25 managing the case and treating?

Page 182

1 MR. GULLIVER:
 2 A. To the best of my knowledge.
 3 CROSBIE, Q.C.:
 4 Q. The assay was done -
 5 MR. GULLIVER:
 6 A. Yes.
 7 CROSBIE, Q.C.:
 8 Q. That was for the oncologist?
 9 MR. GULLIVER:
 10 A. Yeah.
 11 CROSBIE, Q.C.:
 12 Q. Whereas tumour antigens in IHC done in
 13 histology at this time were done for the
 14 pathologist?
 15 MR. GULLIVER:
 16 A. Well, the pathologists interpreted it, but
 17 still being performed for the final benefit of
 18 the oncologist.
 19 CROSBIE, Q.C.:
 20 Q. Well, my information is that it was done for
 21 the pathologist for diagnostic purposes to
 22 assist them in refining their diagnosis, but
 23 that the IHC testing being done in 1997 in
 24 histology was not - was not basically being
 25 used for treatment of patients, it wasn't

Page 183

1 being used for - it wasn't being relied on by
 2 oncologists for therapeutic purposes.
 3 MR. GULLIVER:
 4 A. You mean, IHC overall, or ER/PR testing, in
 5 particular?
 6 CROSBIE, Q.C.:
 7 Q. No, we're talking about a time before ER/PR.
 8 MR. GULLIVER:
 9 A. Okay, so before ER/PR -
 10 CROSBIE, Q.C.:
 11 Q. Yes.
 12 MR. GULLIVER:
 13 A. The pathologist would order based upon their
 14 type of case, type of tumour, type of tissue,
 15 they would request the technologists to
 16 perform a certain number of IHC antibodies
 17 and, you know, they were using that strictly
 18 in their own aid in interpretation of the
 19 patient case.
 20 CROSBIE, Q.C.:
 21 Q. That's what I understand.
 22 MR. GULLIVER:
 23 A. Yes.
 24 CROSBIE, Q.C.:
 25 Q. However it was not being relied on for

Page 184

1 therapeutic purposes by the oncologist?
 2 MR. GULLIVER:
 3 A. To the best of my knowledge, also that's
 4 correct.
 5 CROSBIE, Q.C.:
 6 Q. Which, of course, is something dramatically
 7 different about ER/PR testing?
 8 MR. GULLIVER:
 9 A. Yes.
 10 CROSBIE, Q.C.:
 11 Q. So just to get that picture, up until '97 when
 12 ER/PR was commenced as a test or as a stain
 13 done in histology, what histology was doing
 14 with stains was being done for the diagnosis
 15 or diagnostic purposes of the pathologist, not
 16 for the therapeutic purposes of the
 17 oncologist?
 18 MR. GULLIVER:
 19 A. To the best of my knowledge, yes.
 20 CROSBIE, Q.C.:
 21 Q. That's what I understand. So that when ER/PR
 22 testing was moved over as an IHC procedure to
 23 histology, that's something that made that
 24 task unique, the fact that it was being done
 25 not just for diagnosis but also for therapy?

Page 185

1 MR. GULLIVER:
 2 A. Correct.
 3 CROSBIE, Q.C.:
 4 Q. And, of course, if you got the test wrong,
 5 then the risk was the patient could be
 6 deprived or hormone therapy?
 7 MR. GULLIVER:
 8 A. It all depends on what your definition is of
 9 getting the test wrong. You mean if the test
 10 was performed incorrectly or do you mean it
 11 was not interpreted correctly or -
 12 CROSBIE, Q.C.:
 13 Q. If it yielded an incorrect result for whatever
 14 reason, it could have therapeutic
 15 implications?
 16 MR. GULLIVER:
 17 A. Yes.
 18 CROSBIE, Q.C.:
 19 Q. One of which is that a patient might not get
 20 hormone therapy?
 21 MR. GULLIVER:
 22 A. Yes.
 23 CROSBIE, Q.C.:
 24 Q. So in 1997 we have, I think, Dr. Haegert was
 25 the clinical chief; Dr. Khalifa was the site

Page 186

1 chief; Vern Whelan was the program director,
 2 am I right?
 3 MR. GULLIVER:
 4 A. Uh-hm.
 5 CROSBIE, Q.C.:
 6 Q. And you, sir, was the supervisor or manager of
 7 histology, the histology lab, with its - can
 8 we call it a subsection, IHC section?
 9 MR. GULLIVER:
 10 A. Yes.
 11 CROSBIE, Q.C.:
 12 Q. Okay, and you explained earlier in your
 13 testimony that at this time in 1997, you'd
 14 been off the bench in histology for about ten
 15 years or more even, is that right?
 16 MR. GULLIVER:
 17 A. Yeah.
 18 CROSBIE, Q.C.:
 19 Q. And you had to rely on Mary Butler and Peggy
 20 Welsh to perform procedures, including the IHC
 21 procedures, in an adequate fashion?
 22 MR. GULLIVER:
 23 A. And they had been doing them for a number of
 24 years by this time.
 25 CROSBIE, Q.C.:

Page 187

1 Q. And you also testified that you had the utmost
 2 confidence in both of those techs?
 3 MR. GULLIVER:
 4 A. I thought they were both two good very
 5 technologists.
 6 CROSBIE, Q.C.:
 7 Q. Can you explain, sir, what were your
 8 responsibilities as the supervisor of
 9 anatomical pathology in relation to IHC
 10 testing?
 11 MR. GULLIVER:
 12 A. Overall for IHC testing? I guess, my primary
 13 role was to ensure that obviously we had the
 14 financial resources to maintain that section
 15 of our pathology laboratory. You know, if
 16 there were new antibodies that were being
 17 added to the list of antibodies, to ensure
 18 that those things got - that we had the money
 19 for those. I was also responsible, I guess,
 20 responsible for the staff who were performing
 21 the testing, responsible for the
 22 administrative functions for the lab, you
 23 know, general - what you would expect the
 24 supervisor to be responsible for.
 25 CROSBIE, Q.C.:

Page 188

1 Q. Can we say that you are responsible for the
 2 quality of the output of the lab?
 3 MR. GULLIVER:
 4 A. I really can't agree with that statement.
 5 CROSBIE, Q.C.:
 6 Q. Can you explain that?
 7 MR. GULLIVER:
 8 A. Because I think the way, you know, laboratory
 9 medicine - the practice of laboratory
 10 medicine, in particular in pathology, it
 11 really is a - it's a combined effort between
 12 the technical side and clinical side. I think
 13 that the overall quality for the laboratory
 14 would be a joint responsibility for
 15 administrative side and the clinical side,
 16 however, the assessment of the quality is
 17 really - was the primary function of the
 18 pathologists, and, you know, the technologists
 19 relied upon that feedback from the
 20 pathologists to assess the outcome or output
 21 from all the slides. Whether it was an H & E
 22 slide or an IHC slide, they still relied upon
 23 the pathologist's feedback.
 24 CROSBIE, Q.C.:
 25 Q. The clinical side would have to rely on the

Page 189

1 manager of the lab to ensure that the
 2 technical things that were required to be done
 3 in order to get a quality output were done and
 4 were done right, though?
 5 MR. GULLIVER:
 6 A. That's correct.
 7 CROSBIE, Q.C.:
 8 Q. And what you're explaining is that there had
 9 to be an interaction between the clinical side
 10 and the technical side to ensure that that
 11 objective of good quality product was
 12 continuously being met?
 13 MR. GULLIVER:
 14 A. Yes.
 15 CROSBIE, Q.C.:
 16 Q. And you're saying that it was a shared
 17 responsibility?
 18 MR. GULLIVER:
 19 A. I mean, certainly - I mean, it can't be all
 20 left to the clinical side nor the
 21 administrative side, I mean, it has to be a
 22 shared dual responsibility.
 23 CROSBIE, Q.C.:
 24 Q. And, I guess, we could say that as director of
 25 the - manager of the histology lab, you would

Page 190

1 be responsible for development of new
 2 procedures and the deletion of old ones?
 3 MR. GULLIVER:
 4 A. Not necessarily, no.
 5 CROSBIE, Q.C.:
 6 Q. How so?
 7 MR. GULLIVER:
 8 A. Well, for example, a new procedure, we would
 9 add a new procedure at the request and
 10 approval of the pathologists. Again if the
 11 new procedure was added, you know, they would
 12 verify this is the outcome of the procedure,
 13 review the slides to make sure it's what they
 14 were - that it was satisfactory, and then that
 15 new procedure would become a part of the daily
 16 routine.
 17 CROSBIE, Q.C.:
 18 Q. Well, you explained before that if there was
 19 to be something new done, you had to ensure
 20 that you had the financial resources in place
 21 to do it right. Didn't you just explain that?
 22 MR. GULLIVER:
 23 A. Part of my responsibility is to ensure that we
 24 have the resources, yes.
 25 CROSBIE, Q.C.:

Page 191

1 Q. Registrar, could we bring up Document P-1889,
 2 please. My up and down control doesn't seem
 3 to be working here. We'll probably see the
 4 full letter on the screen. Thank you. So this
 5 was sent - it appears sent to you in March,
 6 1997, but you've told us - or February. I
 7 think there was a March date on it as well.
 8 Yes, March 12th. In any event, that's the
 9 time period, and I think you've explained to
 10 the Commissioner that as far as you can
 11 ascertain you did not receive this?
 12 MR. GULLIVER:
 13 A. I couldn't say that I could or I could not.
 14 When I was shown this, you know, in
 15 preparation for the Commission of Inquiry, you
 16 know, my opinion was I was reading it for the
 17 first time, but I really can't say that I did
 18 not get that ten years ago or did I get it ten
 19 years ago.
 20 CROSBIE, Q.C.:
 21 Q. You don't have a recollection of it, though?
 22 MR. GULLIVER:
 23 A. No.
 24 CROSBIE, Q.C.:
 25 Q. And I think it's not in your own personal file

Page 192

1 or the files that -
 2 MR. GULLIVER:
 3 A. We couldn't find it, no.
 4 CROSBIE, Q.C.:
 5 Q. Yes.
 6 MR. GULLIVER:
 7 A. And I think when I asked - I think it was
 8 something that was an e-mail that Dr. Khalifa
 9 had composed on his computer system, and again
 10 they couldn't verify if it was even sent.
 11 CROSBIE, Q.C.:
 12 Q. I'm not sure where you're getting that it's
 13 an e-mail because, to me, it looks very much
 14 like it has the form of a letter.
 15 MR. GULLIVER:
 16 A. That's just what I was told. I mean, that's -
 17 CROSBIE, Q.C.:
 18 Q. "Dear Mr. Gulliver", and, you know, it doesn't
 19 have any e-mail address on it, and then down
 20 at the bottom, it has a signature line, yours,
 21 where there would normally be a signature
 22 placed in it, but, anyway, the point I want to
 23 get to, there in the second paragraph, you see
 24 where he says, "Mr. Gulliver, I do not think
 25 you fully appreciate the delicacy of this

Page 193

1 test, its clinical consequences, and the
 2 overall emotional charge in the public
 3 regarding this very sensitive procedure".
 4 Whether you received this or not, or recall
 5 receiving this or not, did Dr. Khalifa and you
 6 have a conversation along those lines about
 7 any concern that he harboured that you didn't
 8 appreciate the delicacy of the test?
 9 MR. GULLIVER:
 10 A. Again, not to my knowledge.
 11 CROSBIE, Q.C.:
 12 Q. Is that something that you think you would
 13 remember?
 14 MR. GULLIVER:
 15 A. And again that's what I had said when I read
 16 this, that, you know, when I'm reading this
 17 here - you know, Dr. Khalifa and I had a
 18 fantastic relationship, and I was thinking,
 19 well, you know, if Dr. Khalifa said this and
 20 sent it to me, it's something that I would
 21 have remembered, but I can't say that I did.
 22 CROSBIE, Q.C.:
 23 Q. Doesn't stand out?
 24 MR. GULLIVER:
 25 A. It doesn't stand out, no.

Page 194

1 CROSBIE, Q.C.:
 2 Q. Do you agree or disagree with me when he says,
 3 "I do not think you fully appreciate the
 4 delicacy of the test".
 5 MR. GULLIVER:
 6 A. I think I testified that I certainly think at
 7 that time when this test was being implemented
 8 by Dr. Khalifa, and he was working with Dr.
 9 Prabhakaran in biochemistry, that my knowledge
 10 of the test at that time, certainly this would
 11 be - that would be accurate.
 12 CROSBIE, Q.C.:
 13 Q. So you had a learning curve ahead of you?
 14 MR. GULLIVER:
 15 A. And I think as many of our pathologists did
 16 also. I mean, this is a new test coming into
 17 - it's not just a new procedure, it's a whole
 18 new test coming into the laboratory.
 19 CROSBIE, Q.C.:
 20 Q. Can you say approximately when you became
 21 aware Dr. Khalifa was planning this, this new
 22 test?
 23 MR. GULLIVER:
 24 A. I would - I can't tell you the exact time
 25 frame, Mr. Crosbie. I know there was

Page 195

1 discussions between himself and, I guess, Dr.
 2 Haegert, and the biochemistry people, and I
 3 think that was going on for a few months
 4 before we even - the staff even started
 5 testing anything. So I would say maybe late
 6 '96, you know, like, to this time frame, '97.
 7 CROSBIE, Q.C.:
 8 Q. And you and Dr. Khalifa were present in
 9 various committee meetings where discussion of
 10 this took place during 1997/1998?
 11 MR. GULLIVER:
 12 A. Well - well, whether it's the implementation
 13 or whether now it's been implemented and Dr.
 14 Khalifa is giving updates on it, I think.
 15 CROSBIE, Q.C.:
 16 Q. How close would you say you were to Dr.
 17 Khalifa during the process of developing the
 18 test?
 19 MR. GULLIVER:
 20 A. You mean, was I involved - was I actively
 21 involved in developing the test?
 22 CROSBIE, Q.C.:
 23 Q. However you wish to describe it.
 24 MR. GULLIVER:
 25 A. I wasn't involved at all in the actual

Page 196

1 development of the test. I mean, he worked
 2 specifically with the biochemistry people and,
 3 in particular - in the pathology lab, he
 4 worked with the pathologists, but in
 5 particular he worked with Mary and Peggy, the
 6 two technologists.
 7 CROSBIE, Q.C.:
 8 Q. Did Dr. Khalifa give you any what you describe
 9 as education in the new test?
 10 MR. GULLIVER:
 11 A. I don't remember Dr. Khalifa sitting me down
 12 and giving me a lecture. I just know in
 13 general discussions over a period of time, you
 14 know, that we knew this test was being used
 15 for hormone therapy.
 16 CROSBIE, Q.C.:
 17 Q. Something I left out of the overall picture
 18 that perhaps help pull it together. We
 19 mentioned that when the ER/PR procedure or
 20 test was being performed by biochemistry by
 21 the EIA, or the enzyme immuno assay, this was
 22 being done on frozen sections and did not
 23 involve paraffinized blocks of tissue?
 24 MR. GULLIVER:
 25 A. It was done on fresh tissue, and then it was

Page 197

1 snap frozen, I think.
 2 CROSBIE, Q.C.:
 3 Q. Yeah, so I guess a big part of the rationale
 4 for moving the location within the laboratory
 5 structure of the ER/PR test to histochemistry
 6 is the fact that it was now to be done on
 7 paraffinized blocks of tissue?
 8 MR. GULLIVER:
 9 A. Right, and, therefore, then you had a
 10 permanent block and permanent slide.
 11 CROSBIE, Q.C.:
 12 Q. Yeah, superior in many ways to the previous
 13 method of emulsifying?
 14 MR. GULLIVER:
 15 A. Yes.
 16 CROSBIE, Q.C.:
 17 Q. But it's in histology where they dealt with
 18 tissue in paraffinized blocks?
 19 MR. GULLIVER:
 20 A. Yes.
 21 CROSBIE, Q.C.:
 22 Q. And were already doing the tumour markers that
 23 we spoke of before. You mentioned that Dr.
 24 Khalifa worked with the techs?
 25 MR. GULLIVER:

Page 198

1 A. Yes.
 2 CROSBIE, Q.C.:
 3 Q. Can you describe to what extent or what that
 4 involved, are you able to tell us?
 5 MR. GULLIVER:
 6 A. I really can't tell you to the extent. I
 7 mean, I just know that he worked really well
 8 with the technologists. I know Mary and Peggy
 9 had the utmost respect for Dr. Khalifa. I
 10 think they appreciated any advice or
 11 involvement he had with them, but, you know, I
 12 can't give you a detailed outline.
 13 CROSBIE, Q.C.:
 14 Q. You can't give a detailed description?
 15 MR. GULLIVER:
 16 A. No, no.
 17 CROSBIE, Q.C.:
 18 Q. Okay. Sir, you said that you had no active
 19 role in setting up or supervising these tests
 20 for the ER/PR, in particular. Therefore, we
 21 must infer that it was Dr. Khalifa who set up
 22 and supervised the test.
 23 MR. GULLIVER:
 24 A. Dr. Khalifa set up and supervised the actual
 25 performance of it, and then, you know, it was

Page 199

1 his assessment of reviewing the quality of the
 2 slides being produced by Mary and Peggy, and,
 3 you know, if he decided to use this antibody
 4 dilution or those kinds of variables - my role
 5 would have been to ensure, you know, that we
 6 have resources on hand to buy the reagents and
 7 buy kits. I had discussions with - you know,
 8 at the time Vern Whelan was our program
 9 director. We did - I mean, the most expensive
 10 piece of doing this testing was do you have
 11 the equipment and staff in place. It's adding
 12 two new antibodies to the current list of
 13 antibodies you already perform in your
 14 laboratory, and I know I spoke to Dr. Haegert
 15 and to Vern Whelan to say that while in my
 16 estimate adding these two antibodies to the
 17 IHC part of the laboratory, and the additional
 18 work involved, would probably have cost - I
 19 think it was, like, 10 or 20,000 dollars per
 20 year, and, you know, I had asked Mr. Whelan
 21 then, he should transfer - if biochemistry is
 22 going to stop performing the testing, you
 23 know, whatever money they had in their
 24 operations budget should be transferred over
 25 to the pathology budget to cover off our extra

Page 200

1 expense for the operations side of the
 2 testing. I mean, that would have been more my
 3 involvement with Dr. Khalifa as opposed to
 4 being on the bench overseeing the staff.
 5 CROSBIE, Q.C.:
 6 Q. And the assumption you made as manager is that
 7 no other financial resources were going to be
 8 required in order to do this test to an
 9 appropriate standard than the transfer of the
 10 20,000 or so from the chemistry side?
 11 MR. GULLIVER:
 12 A. Biochemistry.
 13 CROSBIE, Q.C.:
 14 Q. That was your assumption?
 15 MR. GULLIVER:
 16 A. Well, it's my assumption, and it was in
 17 talking to Dr. Khalifa and looking at, you
 18 know, what would be the cost of the reagents
 19 to start up, how many tests do you expect to
 20 perform on a yearly basis, and then multiply
 21 it by the number of patients that we're going
 22 to be testing. We already had two
 23 technologists in the laboratory that were
 24 doing IHC testing for a number of years, so
 25 those same two staff, you know, would perform

Page 201

1 the testing. You know, we had Dr. Khalifa on
 2 staff who was going to do the clinical side,
 3 so I didn't see other parts of the resources
 4 required to start this test up.
 5 CROSBIE, Q.C.:
 6 Q. It wasn't assumed, for example, that any of
 7 the techs would need to be sent out for
 8 training to another institution?
 9 MR. GULLIVER:
 10 A. Dr. Khalifa never assessed that, and never
 11 asked for that, and I think you've heard him
 12 testify that when he came to St. John's, he
 13 was fairly impressed with the amount of IHC
 14 testing taking place and the quality of the
 15 work and the technologists. If Dr. Khalifa
 16 had suggested it or asked for it, I'm sure
 17 funding would have been found for it.
 18 CROSBIE, Q.C.:
 19 Q. We've talked about your responsibility for
 20 quality of output and that it's an interaction
 21 with the clinical side to achieve that, right,
 22 but as manager, you would be responsible as
 23 well for documenting the processes followed in
 24 the lab, is that right, for the documentation
 25 of it?

Page 202

1 MR. GULLIVER:
 2 A. No, I mean the staff, you know, had to
 3 document, you know, what they were doing and
 4 it all depends what documentation that you are
 5 referring to. If it's documenting the fact
 6 that we have a patient and here's a test
 7 performed and here's the results on the
 8 patient, those things are documented, you
 9 know, that's a part of the lab function.
 10 CROSBIE, Q.C.:
 11 Q. Yes, but if you're the supervisor, then it
 12 falls to you, the responsibility falls to you
 13 to ensure that the techs are actually doing
 14 that, right?
 15 MR. GULLIVER:
 16 A. I guess ultimately, yes.
 17 CROSBIE, Q.C.:
 18 Q. Well that's your job as manager.
 19 MR. GULLIVER:
 20 A. A part of my role, yes.
 21 CROSBIE, Q.C.:
 22 Q. You're responsible for those techs doing their
 23 jobs right which includes documenting they're
 24 doing their jobs right.
 25 MR. GULLIVER:

Page 203

1 A. I think people have to take responsibility for
 2 their own job also.
 3 CROSBIE, Q.C.:
 4 Q. Yet there's a manager responsible to ensure
 5 that they are doing so. And in histology,
 6 that was you.
 7 MR. GULLIVER:
 8 A. Yes, I was the manager but I don't think I can
 9 be, you know, watching over the shoulder of 25
 10 or 30 staff every day, I mean staff worked
 11 different schedules, you know. You also have
 12 to assume that staff are going to accept their
 13 responsibility and perform their role as what
 14 they're supposed to do.
 15 CROSBIE, Q.C.:
 16 Q. Ultimately as manager the bucks stops with
 17 you; you're the manager.
 18 MR. GULLIVER:
 19 A. I guess if you apply that line of thinking,
 20 ultimately I guess it rests with the CEO, I
 21 mean because the manager responds--is
 22 responsible to somebody else, then that person
 23 is responsible to somebody else. I mean,
 24 that's how a organization works.
 25 CROSBIE, Q.C.:

Page 204

1 Q. Sir, I thought I was attempting to establish a
 2 fairly uncontroversial proposition, which is
 3 that the manager is responsible for the
 4 quality of the work of the people who work
 5 under him., the manager of histology lab
 6 responsible for the techs in this case?
 7 MR. GULLIVER:
 8 A. I know and the pathology lab structure had
 9 both an administrative and clinical structure,
 10 so it would be a joint responsibility and
 11 accountability for the quality of the work
 12 produced in the laboratory.
 13 CROSBIE, Q.C.:
 14 Q. I wonder if I gave the Registrar this
 15 reference here, I'm looking for the October
 16 9th, 2008 testimony of Dr. Torlakovic and I
 17 may or may not have given you that, Registrar,
 18 sorry, I missed that one. It takes a little
 19 longer if you don't put them on alert that
 20 you're looking for a transcript, you see, page
 21 181 is what I'm looking for. Thanks. So you
 22 can see in the lead up to these questions on
 23 page 181, we--there's information provided, we
 24 assume that there's about 14,000
 25 immunohistochemical tests performed per year

Page 205

1 by your institution?
 2 MR. GULLIVER:
 3 A. I think there's--slides.
 4 CROSBIE, Q.C.:
 5 Q. Slides.
 6 MR. GULLIVER:
 7 A. That would be total slides, that would include
 8 patient slides, control slides, the whole
 9 total.
 10 CROSBIE, Q.C.:
 11 Q. Uh-hm, and about 350 ER/PR.
 12 MR. GULLIVER:
 13 A. I think that's correct, yes.
 14 CROSBIE, Q.C.:
 15 Q. Yes. So then she wanted to know what the
 16 volumes were because I was asking this doctor
 17 from Saskatchewan, this pathologist, for her
 18 feelings as to what the duties of a
 19 pathologist who--should there be a pathologist
 20 responsible to assist in ER/PR IHC testing and
 21 that sort of thing, and she gives an answer
 22 here starting at line 20, I think you can see
 23 it there. You can move that up and down to
 24 suit yourself as well, sir, I think you have a
 25 mouse. And the first one is, she feels that

Page 206

1 where there is volume enough, you should have
 2 a designated specialist to dedicate part of
 3 his or her time for immunohistochemistry
 4 laboratory work alone. You would agree with
 5 that, I guess?
 6 MR. GULLIVER:
 7 A. She's talking about a pathologist there, I
 8 think.
 9 CROSBIE, Q.C.:
 10 Q. She is, yes.
 11 MR. GULLIVER:
 12 A. Yes.
 13 CROSBIE, Q.C.:
 14 Q. You agree with that?
 15 MR. GULLIVER:
 16 A. Sure.
 17 CROSBIE, Q.C.:
 18 Q. And down on page 181, you can move it down if
 19 you wish, around line 5.
 20 THE COMMISSIONER:
 21 Q. 181, line 5?
 22 CROSBIE, Q.C.:
 23 Q. Yes.
 24 THE COMMISSIONER:
 25 Q. Thank you.

Page 207

1 CROSBIE, Q.C.:
 2 Q. Sorry, I meant 181, I apologize.
 3 THE COMMISSIONER:
 4 Q. Okay.
 5 CROSBIE, Q.C.:
 6 Q. Line 5, she's saying "The pathologist would
 7 have to closely interact on a daily basis with
 8 an expert technologist who is in charge of
 9 immunohistochemistry." So the first part of
 10 that, do you agree that there should be close
 11 interaction on a daily basis with a
 12 pathologist?
 13 MR. GULLIVER:
 14 A. Yes.
 15 CROSBIE, Q.C.:
 16 Q. And do you agree there should be an expert
 17 technologist in charge of
 18 immunohistochemistry?
 19 MR. GULLIVER:
 20 A. I think there needs to a technologist, that's
 21 their primary function, I mean, it all depends
 22 on what your definition of an expert
 23 technologist is.
 24 CROSBIE, Q.C.:
 25 Q. Well just going from that idea, somebody who

Page 208

1 has some level of expertise in the process,
 2 was there such a person at your lab in '97,
 3 '98, '99?
 4 MR. GULLIVER:
 5 A. I would have to say that both Peggy Welsh and
 6 Mary Butler have been performing these
 7 procedures for ten years and I would say that
 8 Peggy was probably more knowledgeable for IHC
 9 testing and she was more the lead person for
 10 IHC.
 11 CROSBIE, Q.C.:
 12 Q. And when Dr. Khalifa was present, which was up
 13 until I believe--do you know the month in
 14 1999? Was it summer or fall -
 15 MR. GULLIVER:
 16 A. I think it might have been June, June of '99
 17 when he left.
 18 CROSBIE, Q.C.:
 19 Q. In '99, so in the period when he was there,
 20 did he interact on a daily basis with Peggy
 21 Welsh or anyone else?
 22 MR. GULLIVER:
 23 A. I don't know on a daily basis. I would have
 24 to say, though, on a very frequently basis.
 25 CROSBIE, Q.C.:

Page 209

1 Q. And if you could then go to page 183, which is
 2 back up and around line 10, Dr. Torlakovic is
 3 saying "The pathologist would be in charge of
 4 making sure that daily quality control systems
 5 are functioning correctly and there is
 6 participation in standard quality assurance
 7 programs and would be touching base with other
 8 pathologists to make sure that unusual results
 9 are being reported or communicated." Now,
 10 first of all to take the first of that, in the
 11 period of Dr. Khalifa in respect to ER/PR
 12 testing, what were the quality control
 13 systems?
 14 MR. GULLIVER:
 15 A. Well the quality control system was the
 16 technologist, as you've heard, would run a
 17 known positive control with, you know, with
 18 the ER and the PR, so a positive ER, a
 19 positive PR, those controls would be read by
 20 Dr. Khalifa to verify the quality of the
 21 controls and to make sure the quality of the
 22 staining and then any feedback back to the
 23 laboratory.
 24 CROSBIE, Q.C.:
 25 Q. That was the quality control system. The

Page 210

1 positive external control?
 2 MR. GULLIVER:
 3 A. Well some of the daily quality control system,
 4 I think she's referring to there the controls,
 5 the control slides.
 6 CROSBIE, Q.C.:
 7 Q. Okay, well I asked you what were the daily
 8 quality control systems is the word she uses
 9 here and you're referring to the slides, the
 10 external positive control slides, yes.
 11 MR. GULLIVER:
 12 A. Yes.
 13 CROSBIE, Q.C.:
 14 Q. Is there anything else you'd have? What other
 15 quality controls -
 16 MR. GULLIVER:
 17 A. Well I guess then having a pathologist review
 18 the slides to ensure that the procedure is
 19 working fine.
 20 CROSBIE, Q.C.:
 21 Q. The patient slides that were to be
 22 interpreted?
 23 MR. GULLIVER:
 24 A. And the control slides.
 25 CROSBIE, Q.C.:

Page 211

1 Q. Along with the control slides.
 2 MR. GULLIVER:
 3 A. Yes.
 4 CROSBIE, Q.C.:
 5 Q. That was the quality control.
 6 MR. GULLIVER:
 7 A. For that particular procedure.
 8 CROSBIE, Q.C.:
 9 Q. Uh-hm. Now, participation I think we know in
 10 standard quality assurance programs that was a
 11 little bit of an issue because there wasn't
 12 any, was there?
 13 MR. GULLIVER:
 14 A. In what kind of quality assurance programs?
 15 You mean external proficiency testing programs
 16 or -
 17 CROSBIE, Q.C.:
 18 Q. Well to take that as an example, yes.
 19 MR. GULLIVER:
 20 A. Well at that point in time in pathology, the
 21 pathologists were enrolled in external
 22 proficiency in getting samples in to do
 23 interpretations and get assessment on it.
 24 There was no external proficiency testing in
 25 particular for the IHC part of the pathology

Page 212

1 lab.
 2 CROSBIE, Q.C.:
 3 Q. Do you mean it wasn't available or you just
 4 didn't have it in that lab?
 5 MR. GULLIVER:
 6 A. I don't think either, we didn't have it and I
 7 don't think in '97 it was available. I would
 8 have thought that if it was available, that
 9 would have been something that Dr. Khalifa
 10 probably would have been aware of and probably
 11 would have requested.
 12 CROSBIE, Q.C.:
 13 Q. Okay, but you don't know.
 14 MR. GULLIVER:
 15 A. I can't say for sure, no.
 16 CROSBIE, Q.C.:
 17 Q. You can't say that the UK system of external
 18 proficiency testing was not available in '97?
 19 You don't know that?
 20 MR. GULLIVER:
 21 A. I can't say if it was or if it was not.
 22 CROSBIE, Q.C.:
 23 Q. Okay.
 24 MR. GULLIVER:
 25 A. And I don't know what time it came in because

Page 213

1 Dr. Ejeckam who came with us in 2003, it
 2 wasn't until 2005 that he suggests that we
 3 should enrol in UK NEQAS, so I don't know
 4 when that program was -
 5 CROSBIE, Q.C.:
 6 Q. You don't know, so that's the answer.
 7 MR. GULLIVER:
 8 A. No.
 9 CROSBIE, Q.C.:
 10 Q. As the lab manager, did you have
 11 responsibility for training of techs?
 12 MR. GULLIVER:
 13 A. Not training directly, no.
 14 CROSBIE, Q.C.:
 15 Q. Did you have responsibility to ensure that
 16 they were adequately trained to the tasks they
 17 were doing?
 18 MR. GULLIVER:
 19 A. Pretty well yes, I mean it all depends, you
 20 know, as you realize pathology is a process,
 21 you're talking about technologists performing
 22 the functions in the pre-analytical part of
 23 pathology, they do the embedding of blocks,
 24 the cutting of blocks, the routine staining,
 25 the histochemical staining,

Page 214

1 immunohistochemical stainings, so what you
 2 pretty well rely upon is that you have your
 3 other technologists and senior technologists
 4 to assist and train new staff into those
 5 functions.
 6 CROSBIE, Q.C.:
 7 Q. And you had responsibility for budgeting, for
 8 staffing, staffing levels.
 9 MR. GULLIVER:
 10 A. Issues and -
 11 CROSBIE, Q.C.:
 12 Q. Dealing with unions, purchasing reagents and
 13 other things.
 14 MR. GULLIVER:
 15 A. Yes.
 16 CROSBIE, Q.C.:
 17 Q. All that. When we looked, might have been
 18 yesterday, at the Wegrynowski report, there
 19 was a recommendation in there, she used the
 20 word or the term "medical section head" to be
 21 designated. That was one of the
 22 recommendations. And so in my understanding,
 23 I guess this would be the pathologist who
 24 we've just read, Dr. Torlakovic's testimony,
 25 would be the daily contact person resource -

Page 215

1 MR. GULLIVER:
 2 A. For the IHC.
 3 CROSBIE, Q.C.:
 4 Q. For IHC.
 5 MR. GULLIVER:
 6 A. Yes.
 7 CROSBIE, Q.C.:
 8 Q. That's what she's calling the medical section
 9 head. Is that a position which is being
 10 created or recognized at this point in time?
 11 MR. GULLIVER:
 12 A. Well it's Dr. Ford Elms.
 13 CROSBIE, Q.C.:
 14 Q. So he's doing that function?
 15 MR. GULLIVER:
 16 A. Yes, but I think he's officially called the
 17 director of IHC lab.
 18 CROSBIE, Q.C.:
 19 Q. Director.
 20 MR. GULLIVER:
 21 A. I don't think it's called medical section
 22 head.
 23 CROSBIE, Q.C.:
 24 Q. Okay, same thing though, you would think.
 25 MR. GULLIVER:

Page 216

1 A. Yes.
 2 CROSBIE, Q.C.:
 3 Q. And so that, although there is no title or
 4 described function of director or medical
 5 section head, Dr. Khalifa effectively
 6 functioned in that role, that's more or less
 7 what you've told us.
 8 MR. GULLIVER:
 9 A. I'd have to say, yes.
 10 CROSBIE, Q.C.:
 11 Q. And then Dr. Khalifa leaves in June, 1999, who
 12 was in place as site chief, was Dr. Wadden
 13 acting for a period of time?
 14 MR. GULLIVER:
 15 A. I think Dr. Wadden might have been--that was a
 16 very, very short time.
 17 CROSBIE, Q.C.:
 18 Q. Very short time.
 19 MR. GULLIVER:
 20 A. Primarily it was Dr. Sushil Parai who was
 21 appointed site chief of the Health Sciences.
 22 CROSBIE, Q.C.:
 23 Q. What I'm getting at is Dr. Wadden didn't
 24 really assert herself to have an effect or
 25 play a role in IHC testing?

Page 217

1 MR. GULLIVER:
 2 A. No.
 3 CROSBIE, Q.C.:
 4 Q. So really we go from Dr. Khalifa at the end of
 5 June '99 to Dr. Parai and he takes over
 6 whatever the function was that Dr. Khalifa was
 7 performing.
 8 MR. GULLIVER:
 9 A. As site chief.
 10 CROSBIE, Q.C.:
 11 Q. As site chief. However, we've heard, I think
 12 as well, that Dr. Parai didn't have an
 13 interest or, well an interest in IHC testing
 14 and that his role was pretty much limited to
 15 reading the control slides, is that about
 16 right?
 17 MR. GULLIVER:
 18 A. That's for a time period, yes.
 19 CROSBIE, Q.C.:
 20 Q. Well, he would be the site chief up to March
 21 2005 is what I have here.
 22 MR. GULLIVER:
 23 A. No, I mean a time period where it was Dr.
 24 Parai who was then reading the control slides
 25 from the IHC lab and then at some point, that

Page 218

1 changed and the individual pathologist at the
 2 Health Sciences were then, they were all
 3 taking on a part of that responsibility.
 4 CROSBIE, Q.C.:
 5 Q. So what else did Dr. Parai do? He didn't do
 6 as much as Dr. Khalifa did in terms of having
 7 interaction with IHC, did he?
 8 MR. GULLIVER:
 9 A. Not to my knowledge.
 10 CROSBIE, Q.C.:
 11 Q. In fact, he had very little interaction with
 12 the lab, is that correct?
 13 MR. GULLIVER:
 14 A. With the IHC lab?
 15 CROSBIE, Q.C.:
 16 Q. Yes.
 17 MR. GULLIVER:
 18 A. I think after Dr. Khalifa left, I think Peggy
 19 or Mary probably were interactive with Dr.
 20 Chittal who was a pathologist on staff for a
 21 long time and he did have a fair bit of IHC
 22 experience and interest.
 23 CROSBIE, Q.C.:
 24 Q. And Dr. Chittal, when did he leave the scene?
 25 MR. GULLIVER:

Page 219

1 A. Dr. Chittal retired maybe--might be two years
 2 now.
 3 CROSBIE, Q.C.:
 4 Q. So are you saying to the Commission here that
 5 Dr. Chittal filled the role of giving daily
 6 interaction and guidance to laboratory staff?
 7 MR. GULLIVER:
 8 A. He certainly didn't fill the role Dr. Khalifa
 9 left, but in the absence of Dr. Khalifa, I
 10 think that's the pathologist--and Dr. Chittal
 11 was at the Health Sciences maybe since
 12 1981/'82 and I think that's the clinical
 13 person who Mary and Peggy probably went to
 14 looking for any questions or guidance or--
 15 because they already had an established
 16 relationship working together as technologist,
 17 pathologist since the early '80's.
 18 CROSBIE, Q.C.:
 19 Q. Dr. Khalifa had a formal position of site
 20 chief.
 21 MR. GULLIVER:
 22 A. Yes.
 23 CROSBIE, Q.C.:
 24 Q. Dr. Parai had the formal position of site
 25 chief.

Page 220

1 MR. GULLIVER:
 2 A. Yes.
 3 CROSBIE, Q.C.:
 4 Q. Dr. Chittal had no position as site chief.
 5 MR. GULLIVER:
 6 A. At some point Dr. Chittal is our site chief
 7 for a small--for again, a short period of
 8 time, Mr. Crosbie.
 9 CROSBIE, Q.C.:
 10 Q. Can you say when?
 11 MR. GULLIVER:
 12 A. I can't tell you the exact time frame, you
 13 know.
 14 CROSBIE, Q.C.:
 15 Q. Is it within the 1997 through 2005 time
 16 period?
 17 MR. GULLIVER:
 18 A. No, I don't think so.
 19 CROSBIE, Q.C.:
 20 Q. So he did not hold a formal position of site
 21 chief during that period.
 22 MR. GULLIVER:
 23 A. No.
 24 CROSBIE, Q.C.:
 25 Q. He did not hold the position such as medical

Page 221

1 director or medical section head during that
 2 period in relation to the IHC lab?
 3 MR. GULLIVER:
 4 A. Well there was no position as such during that
 5 time frame regardless.
 6 CROSBIE, Q.C.:
 7 Q. Correct. So you're saying that informally
 8 this gentleman gave some assistance to the
 9 techs on a periodic basis?
 10 MR. GULLIVER:
 11 A. Pretty well, yes.
 12 CROSBIE, Q.C.:
 13 Q. Something which Dr. Parai, as site chief,
 14 didn't do?
 15 MR. GULLIVER:
 16 A. I don't think so, no.
 17 CROSBIE, Q.C.:
 18 Q. Now you were the lab manager until, right from
 19 the beginning of '97 to October, 2001.
 20 MR. GULLIVER:
 21 A. 2001.
 22 CROSBIE, Q.C.:
 23 Q. And then Mr. Dyer took over from you.
 24 MR. GULLIVER:
 25 A. A few months afterwards, yes.

Page 222

1 CROSBIE, Q.C.:
 2 Q. The majority of the period then, from 1997 to
 3 2005, you were the lab manager?
 4 MR. GULLIVER:
 5 A. It was about half, I guess.
 6 CROSBIE, Q.C.:
 7 Q. A bit more than half.
 8 MR. GULLIVER:
 9 A. To 2005?
 10 CROSBIE, Q.C.:
 11 Q. October 2001, we're talking about '97, '98,
 12 '99, 2000.
 13 MR. GULLIVER:
 14 A. From '97 to '01, I was the only manager.
 15 CROSBIE, Q.C.:
 16 Q. Pardon?
 17 MR. GULLIVER:
 18 A. From '97 to October, 2001, all that time frame
 19 I was the pathology manager.
 20 CROSBIE, Q.C.:
 21 Q. Exactly, so that's four and almost five years.
 22 Almost five years from '97 to October -
 23 MR. GULLIVER:
 24 A. Well it was March '97 to October '01, so it's
 25 four years and a bit, whatever, maybe, yes.

Page 223

1 CROSBIE, Q.C.:
 2 Q. Four and a half years and then Mr. Dyer took
 3 over. So Dr. Ejeckam, we've heard, came on
 4 the scene and he became the resource person
 5 for people who had questions or issues in the
 6 lab, but he didn't come on the scene until,
 7 what is it, September 2000?
 8 MR. GULLIVER:
 9 A. No, I think he comes in late 2002, I think.
 10 CROSBIE, Q.C.:
 11 Q. Perhaps Ms. Chaytor knows. Okay, so late 2002
 12 it is, Dr. Ejeckam comes on the scene.
 13 MR. GULLIVER:
 14 A. Uh-hm.
 15 CROSBIE, Q.C.:
 16 Q. So what I'm getting from this is that from the
 17 time Dr. Khalifa leaves in June '99 to the
 18 time Dr. Ejeckam comes on the scene in
 19 September, 2002, with the exception of the
 20 gentleman you mentioned who hasn't appeared o
 21 the record here all that much, no one was
 22 doing the job of daily interacting with the
 23 techs to help them with any problems they were
 24 having in performing their ER/PR IHC
 25 procedure?

Page 224

1 MR. GULLIVER:
 2 A. Well I think and your answer is right and I
 3 think that, you know, if there was a problem
 4 encountered by the technologists, they would
 5 informally go to Dr. Chittal.
 6 THE COMMISSIONER:
 7 Q. Mr. Crosbie, when there's a convenient spot,
 8 we'll break for the luncheon break.
 9 CROSBIE, Q.C.:
 10 Q. Thanks for the reminder. As you've noticed
 11 with lawyers before, they tend to forget what
 12 time it is.
 13 THE COMMISSIONER:
 14 Q. Uh-hm.
 15 CROSBIE, Q.C.:
 16 Q. Thank you. Well I have some other things to
 17 ask about and we'll do that after lunch at
 18 what time, Commissioner?
 19 THE COMMISSIONER:
 20 Q. At 2:15.
 21 (ADJOURNED FOR LUNCH)
 22 THE COMMISSIONER:
 23 Q. Please be seated. Mr. Crosbie?
 24 CROSBIE, Q.C.:
 25 Q. Thank you, Commissioner. I'd like to talk,

Page 225

1 Mr. Gulliver, about antigen retrieval and in
 2 simple terms what we are trying to accomplish
 3 here is to use--if we have a method for
 4 uncovering the cross linkages that obscure the
 5 antigen sites to which we want our antibodies
 6 to bind and then be visible under the
 7 microscope as brown dots, simplistic, but
 8 that's about the right idea?
 9 MR. GULLIVER:
 10 A. Correct.
 11 CROSBIE, Q.C.:
 12 Q. And so to achieve antigen retrieval or to
 13 reveal these antigen sites or these receptor
 14 sites, the method that we've been talking
 15 about most of the time here is heat, the use
 16 of heat.
 17 MR. GULLIVER:
 18 A. A part of it is using heat.
 19 CROSBIE, Q.C.:
 20 Q. There are other methods though and Trypsin
 21 would be an example?
 22 MR. GULLIVER:
 23 A. Trypsin is used also at the front end of IHC
 24 testing, but not as a part of antigen
 25 retrieval for the ER/PR.

Page 226

1 CROSBIE, Q.C.:
 2 Q. Just explain what Trypsin is?
 3 MR. GULLIVER:
 4 A. You're getting to technical terms there now
 5 that are not at my level.
 6 CROSBIE, Q.C.:
 7 Q. Well why, they're certainly not at our level
 8 either, I guess, if you're--we're not looking
 9 for an ultra technical description, just what
 10 it does and what it's used for.
 11 MR. GULLIVER:
 12 A. Trypsin is used as a, I think it's used as a
 13 protein digestion that it kind of, you apply
 14 to the slides and it, say in simple terms,
 15 kind of sucks out the things that you don't
 16 want staining.
 17 CROSBIE, Q.C.:
 18 Q. It's used a part of the peroxidase, anti-
 19 peroxidase method?
 20 MR. GULLIVER:
 21 A. Procedure, yes.
 22 CROSBIE, Q.C.:
 23 Q. Procedure. It can be used in ER/PR testing
 24 process?
 25 MR. GULLIVER:

Page 227

1 A. I think it can, yes.
 2 CROSBIE, Q.C.:
 3 Q. So a couple of times--more than a couple of
 4 times, numerous times you've made reference to
 5 boiling on a hot plate, for example, I've made
 6 a note here "manually take your slides and put
 7 them on a hot plate and boil them." And you
 8 said that a couple of times.
 9 MR. GULLIVER:
 10 A. And what I'm meaning there is that you
 11 actually take the substrate buffer that you're
 12 using, that you're boiling to a certain
 13 temperature, which is in like a pyrex dish,
 14 then your slides go in that dish which is on
 15 the hot plate.
 16 CROSBIE, Q.C.:
 17 Q. So it's not like a pot with the slides in it
 18 on a hot plate, it's something like a coplin
 19 jar in the solution in the pot on a hot plate,
 20 is that what you mean?
 21 MR. GULLIVER:
 22 A. Yes.
 23 CROSBIE, Q.C.:
 24 Q. Can I have brought up document P-0565 please?
 25 And there, probably in the third paragraph

Page 228

1 there, at the time you're talking about '97,
 2 so you're giving a history now in this
 3 document to Dr. Williams and you're saying
 4 "1997 switched to ER/PR testing from
 5 biochemical assay, which involved freezing
 6 tumour tissue, mashing tissue, that assay for
 7 ER/PR" and that's what we talked about a
 8 little bit before lunch. Then you go on to
 9 say "At the time, immunohistochemistry method
 10 gave better results than the old biochemical
 11 assay. The new method involved a manual
 12 procedure to boil slides in a solution on a
 13 hot plate to unmask as best possible antigen
 14 sites in the patient's tissue." And so there
 15 you are again describing what was done in our
 16 lab here commencing in 1997, this time
 17 describing it in writing to Dr. Williams.
 18 MR. GULLIVER:
 19 A. Just the basic outline of what was done, yes.
 20 CROSBIE, Q.C.:
 21 Q. Just the basics. And Ms. Chaytor, I have
 22 here, asked you "At some time did St. John's
 23 use other than a hot plate?" And your answer
 24 was "No."
 25 MR. GULLIVER:

Page 229

1 A. Well, because you can use--I've learned since
 2 then you can--people do use pressure cookers
 3 and people do use microwave ovens to heat the
 4 substrate solution. We always use the hot
 5 plate and then at some point, I think DAKO
 6 came out then with like a waterbath that you
 7 could use to heat up your substrate solution.
 8 CROSBIE, Q.C.:
 9 Q. Did you adopt the waterbath technique at some
 10 point?
 11 MR. GULLIVER:
 12 A. Well it's not a technique, it's just replacing
 13 the hot plate.
 14 CROSBIE, Q.C.:
 15 Q. But did you?
 16 MR. GULLIVER:
 17 A. Yes, we did.
 18 CROSBIE, Q.C.:
 19 Q. Can I have document P-3050? You'll see on the
 20 top left there, "Source is Eastern Health,
 21 source, Terry Gulliver. It's a protocol sheet
 22 for high temperature epitope unmasking." Do
 23 you recognize this document?
 24 MR. GULLIVER:
 25 A. Well I gather the document is from the

Page 230

1 laboratory.
 2 CROSBIE, Q.C.:
 3 Q. You're named as the source.
 4 MR. GULLIVER:
 5 A. I gathered them from the pathology lab and
 6 provided all documents for ER/PR to the
 7 inquiry.
 8 CROSBIE, Q.C.:
 9 Q. Do you know what this designation, volume 14,
 10 page 188 is over there in the top right?
 11 MR. SIMMONS:
 12 Q. Commissioner, the same question about that Mr.
 13 Gulliver wouldn't know the answer, that's just
 14 the indexing method used by us as we produce
 15 the documents to the Commission, so that just
 16 indicates the volume of production and page
 17 numbering of the production.
 18 CROSBIE, Q.C.:
 19 Q. Well there's the answer. You can--or I can,
 20 go over to the second page. There's your
 21 pressure cooker mentioned there, item A,
 22 autoclave. There seems to be a microwave oven
 23 method and then they have here at C, hot water
 24 bath method and there under hot water bath on
 25 page 2 of the exhibit, DAKO is saying "set up

Page 231

1 a hot water bath, 95 to 99 degrees C by
 2 placing water into a large vessel, such as a
 3 kitchen pot on a hot plate." Is that
 4 effectively the protocol that your lab was
 5 following?
 6 MR. GULLIVER:
 7 A. To the best of my knowledge, yes. And I think
 8 they used to use, like, you know, a Corning,
 9 you know, the plain glass Corning dish.
 10 CROSBIE, Q.C.:
 11 Q. Uh-hm, rather than the kitchen pot, you mean?
 12 MR. GULLIVER:
 13 A. Yeah.
 14 CROSBIE, Q.C.:
 15 Q. When it's put that way, it sounds a bit crude
 16 to the layperson, you would agree?
 17 MR. GULLIVER:
 18 A. Yeah.
 19 CROSBIE, Q.C.:
 20 Q. Okay. Hot plates and kitchen pots. But you
 21 said at some point you switched to, I guess
 22 what they describe on the first page, the
 23 pressure cooker?
 24 MR. GULLIVER:
 25 A. No, we never ever switched to pressure cooker.

Page 232

1 CROSBIE, Q.C.:
 2 Q. Okay, what would you call it then, a
 3 waterbath?
 4 MR. GULLIVER:
 5 A. Yes, when they were first doing this testing,
 6 in order to heat the substrate solution, it
 7 was boiled on a hot plate. At some point DAKO
 8 did come out with like a waterbath you could
 9 use in place of that.
 10 CROSBIE, Q.C.:
 11 Q. I think I may be able to help -
 12 MR. GULLIVER:
 13 A. But we never ever used a pressure cooker
 14 method or a microwave oven method.
 15 CROSBIE, Q.C.:
 16 Q. I might be able to help you if we go to
 17 Exhibit P-2888? And we go along to page 3 of
 18 that. Now this doesn't seem to be the
 19 document I was looking for, actually, Mr.
 20 Gulliver. What I thought I had there was and
 21 I believe it's here in the documents
 22 somewhere, is the acquisition of a waterbath
 23 by the lab was acquired on October 27, 1999,
 24 would that seem about right?
 25 MR. GULLIVER:

Page 233

1 A. That got to be, yeah, I think so.
 2 CROSBIE, Q.C.:
 3 Q. And in fact, it seems that you were given the
 4 waterbath by DAKO, after all, I guess, you
 5 were spending a lot of money with DAKO.
 6 MR. GULLIVER:
 7 A. Probably, yeah.
 8 CROSBIE, Q.C.:
 9 Q. So they sort of threw that in and do you think
 10 then that from around that period, late '99
 11 you started using a waterbath method?
 12 MR. GULLIVER:
 13 A. Yes.
 14 CROSBIE, Q.C.:
 15 Q. As opposed to the cruder sounding hot plate.
 16 MR. GULLIVER:
 17 A. By using a hot plate with a kitchen pot.
 18 CROSBIE, Q.C.:
 19 Q. Kitchen pot, yes, okay. Can we now go to
 20 Document 1853, and I'm interested in page two,
 21 please. As you can see, sir, these are
 22 answers to interrogatories, and the question
 23 three appears there, "Please attach a copy of
 24 the bench manual for the DAKO system,
 25 specifically written methodology on antigen

Page 234

1 retrieval controls, negative and positive,
 2 etc", and then if we carry on over, are those
 3 your initials at the top of page six?
 4 MR. GULLIVER:
 5 A. Yes, it is.
 6 CROSBIE, Q.C.:
 7 Q. That's TR for Terry Gulliver?
 8 MR. GULLIVER:
 9 A. TG.
 10 CROSBIE, Q.C.:
 11 Q. Yes, sorry, it is TG. It reads like TR, but
 12 that's your initial. You have marked there,
 13 that's your handwriting, "Immunoperoxidase,
 14 step by step procedure".
 15 MR. GULLIVER:
 16 A. Correct.
 17 CROSBIE, Q.C.:
 18 Q. And if we go down there, we can see - see the
 19 word "trypsin" in Item 2 there under
 20 procedure?
 21 MR. GULLIVER:
 22 A. Yeah.
 23 CROSBIE, Q.C.:
 24 Q. And I think it appears there as well above,
 25 appears a second time. Just check it against

Page 235

1 my paper copy. Under day two, it says -
 2 there's the word "trypsin" again, which you
 3 mentioned to us a little while ago. So why
 4 did you - first of all, these interrogatories
 5 were addressed to Ms. Predham, as you
 6 remember, but she obviously required the
 7 assistance of other people and on this
 8 occasion, you, to answer the interrogatories
 9 accurately and correctly.
 10 MR. GULLIVER:
 11 A. Yes.
 12 CROSBIE, Q.C.:
 13 Q. So the question that this was meant to answer
 14 was, "Attach a copy of the bench manual for
 15 the DAKO system, specifically written
 16 methodology on antigen retrieval controls,
 17 negative and positive, etc". My question is
 18 why did you give us the immunoperoxidase step
 19 by step procedure using trypsin?
 20 MR. GULLIVER:
 21 A. Is there anything else attached to this?
 22 CROSBIE, Q.C.:
 23 Q. Yes, feel free to have a look. There's a fe
 24 more pages in the attachment.
 25 MR. GULLIVER:

Page 236

1 A. Well, I guess this is the procedure that was
 2 used, the protocol for IHC testing. The
 3 antigen retrieval process is applied
 4 specifically for ER/PR before the slides even
 5 get to the actual IHC procedure. So the
 6 trypsin is added, and it's not added to all
 7 antibodies, it's added to some antibodies
 8 during the actual step by step procedure.
 9 CROSBIE, Q.C.:
 10 Q. I'm sorry, is this being done at a certain
 11 point in time and not at another point in
 12 time?
 13 MR. GULLIVER:
 14 A. Yeah.
 15 CROSBIE, Q.C.:
 16 Q. And when was it abandoned?
 17 MR. GULLIVER:
 18 A. Oh, the trypsin was not abandoned. At some
 19 point in time -
 20 CROSBIE, Q.C.:
 21 Q. For ER/PR testing now specifically?
 22 MR. GULLIVER:
 23 A. I can't answer that question. I mean, I've
 24 never done an ER/PR test. I can tell you some
 25 basic answers to some of the questions here,

Page 237

1 but, you know, if you want to get into more
 2 technical detail, you'll have to speak to the
 3 technologists who are actually performing the
 4 test.
 5 CROSBIE, Q.C.:
 6 Q. So, in fact, you can't tell us whether trypsin
 7 is still in use, or in use up to when the
 8 testing was being performed?
 9 MR. GULLIVER:
 10 A. Trypsin is used still for some antibodies,
 11 even in the Ventana system.
 12 CROSBIE, Q.C.:
 13 Q. But you can't tell us whether it was being
 14 used for ER/PR testing?
 15 MR. GULLIVER:
 16 A. I can't tell you definitively right now, no.
 17 So what you have here, the first couple of
 18 pages, Mr. Crosbie, is the actual step by step
 19 procedure for doing IHC antibodies. The ER/PR
 20 antigen retrieval is applied before the slides
 21 get to this part of the procedure. What
 22 you're seeing here next is the - it's just
 23 documentation from the manufacturer that this
 24 is the DAKO retrieval solution that's used for
 25 antigen retrieval.

Page 238

1 CROSBIE, Q.C.:
 2 Q. And also you've got isolated there with your
 3 own markings, DAKO antigen retrieval, step by
 4 step?
 5 MR. GULLIVER:
 6 A. And this is the procedure for the antigen
 7 retrieval piece, yes.
 8 CROSBIE, Q.C.:
 9 Q. And it mentions waterbath specifically?
 10 MR. GULLIVER:
 11 A. Uh-hm.
 12 CROSBIE, Q.C.:
 13 Q. So I would have guessed that after you were
 14 given the waterbath in late 1999, you adopted
 15 what's set out there, recommended procedure,
 16 waterbath?
 17 MR. GULLIVER:
 18 A. But this procedure is still the same whether
 19 you're using a waterbath or using a hot plate
 20 or a kitchen pot. It's still the same
 21 procedure. You still have to use our pH
 22 solution, you still have to dewax your slides
 23 and rehydrate your tissue sections, you still
 24 got to immerse them into the retrieval
 25 solution.

Page 239

1 CROSBIE, Q.C.:
 2 Q. So your evidence is you were using trypsin, as
 3 described in the step by step procedure at
 4 page six, and the recommended waterbath?
 5 MR. GULLIVER:
 6 A. But trypsin is not used - trypsin is not used
 7 as an antigen retrieval for ER/PR antibodies.
 8 Trypsin is used for - is applied to most
 9 antibodies for IHC testing.
 10 CROSBIE, Q.C.:
 11 Q. One final thing before we leave page nine - by
 12 all means, have a look, but if you -
 13 MR. GULLIVER:
 14 A. I'm still scrolling - do you want me to scroll
 15 back?
 16 CROSBIE, Q.C.:
 17 Q. Page nine, when you're ready. Just one more
 18 thing, a few lines into that paragraph that
 19 you have marked off, it says, "Heat waterbath
 20 to 95/99 centigrade. Do not boil". Any
 21 particular significance to that advice?
 22 MR. GULLIVER:
 23 A. Well, I mean, they always told the staff that
 24 you don't allow your retrieval solution to
 25 boil, which is a much higher temperature than

Page 240

1 that.
 2 CROSBIE, Q.C.:
 3 Q. Well, some of us may be struck by the fact
 4 that you repeatedly referred to boiling.
 5 MR. GULLIVER:
 6 A. Oh, I think you're just taking things too
 7 literally. What is meant is that instead of
 8 putting your solution on a hot plate and then
 9 you turn it up and let it boil and bubble, and
 10 then wait for it to cool down to 95/99, you
 11 actually apply a more even heat until the
 12 solution reaches up to 95/99 degree
 13 temperature.
 14 CROSBIE, Q.C.:
 15 Q. When the - well, it's called kitchen pot and
 16 hot plate method was being used, did you - you
 17 were ten years off the bench at that point in
 18 time in '97. Did you work with the techs to
 19 see how they were performing that part of the
 20 procedure?
 21 MR. GULLIVER:
 22 A. I didn't work with the techs to see it, but, I
 23 mean, I was in the lab enough to see the times
 24 when they were doing the procedure, yes.
 25 CROSBIE, Q.C.:

Page 241

1 Q. Do you know how they controlled for the
 2 temperature to make sure -
 3 MR. GULLIVER:
 4 A. With a thermometer.
 5 CROSBIE, Q.C.:
 6 Q. The slides were not in a solution which
 7 boiled?
 8 MR. GULLIVER:
 9 A. They had a thermometer in it, like, a
 10 thermometer.
 11 CROSBIE, Q.C.:
 12 Q. In which?
 13 MR. GULLIVER:
 14 A. Into the solution.
 15 CROSBIE, Q.C.:
 16 Q. In the solution in which the slides were
 17 placed?
 18 MR. GULLIVER:
 19 A. Exactly. To make sure it's at 95/99 degrees,
 20 there was a thermometer placed into it so they
 21 know when it reached up to that range.
 22 CROSBIE, Q.C.:
 23 Q. And they'd keep it at that range for how long?
 24 MR. GULLIVER:
 25 A. Well, the time was 20 minutes that they used

Page 242

1 to incubate for.
 2 CROSBIE, Q.C.:
 3 Q. And you know this, though, not from having
 4 watched them do it, or taken them through the
 5 process of doing it, you know that from what's
 6 set out here?
 7 MR. GULLIVER:
 8 A. No, I know that from speaking to the
 9 technologists and I know that enough times
 10 over the years that just by chance I might
 11 have been out in the lab when they were doing
 12 their procedure to verify that.
 13 CROSBIE, Q.C.:
 14 Q. How was the twenty minutes timed for?
 15 MR. GULLIVER:
 16 A. How was it timed?
 17 CROSBIE, Q.C.:
 18 Q. Uh-hm.
 19 MR. GULLIVER:
 20 A. It was - in all parts of pathology, there's
 21 multiple different stains that are performed
 22 and different timings for different solutions,
 23 whether it's an IHC test, histochemical test,
 24 or an H & E stain, and they use multiple
 25 timers. So you have a lab timer clock that

Page 243

1 you set your time for twenty minutes, and then
 2 when the time is up, the buzzer goes off, you
 3 take your things out, and do the next - enter
 4 the next step.
 5 CROSBIE, Q.C.:
 6 Q. I guess in lay terms, an alarm clock?
 7 MR. GULLIVER:
 8 A. Pretty well, yeah.
 9 CROSBIE, Q.C.:
 10 Q. A timer that would make an audible noise and
 11 you'd know your time was up?
 12 MR. GULLIVER:
 13 A. Yes.
 14 CROSBIE, Q.C.:
 15 Q. And you saw that, did you?
 16 MR. GULLIVER:
 17 A. Hundreds of times.
 18 CROSBIE, Q.C.:
 19 Q. Was it always used?
 20 MR. GULLIVER:
 21 A. To my knowledge, yes.
 22 CROSBIE, Q.C.:
 23 Q. Of course, you didn't see this procedure done
 24 every time it was done?
 25 MR. GULLIVER:

Page 244

1 A. Obviously not, no, but my experience with the
 2 technologists is they had a procedure to
 3 follow and that's the procedure they followed.
 4 Again whether it's an ER/PR or an H & E stain,
 5 that's the procedure that you follow.
 6 CROSBIE, Q.C.:
 7 Q. Document 1889, please. We looked at this
 8 before. That's the Dr. Khalifa letter which
 9 you don't recall receiving, and, of course, we
 10 looked at the part where it says, "I do not
 11 think you appreciate the delicacy of this
 12 test", and I think you told us that at the
 13 outset you may not have, but you learned, is
 14 that true?
 15 MR. GULLIVER:
 16 A. I think we all learned, yes. This was a new
 17 test that was being introduced, and Dr.
 18 Khalifa was pretty well the only - even the
 19 only pathologist that had knowledge about this
 20 test.
 21 CROSBIE, Q.C.:
 22 Q. Was it a delicate test?
 23 MR. GULLIVER:
 24 A. I think you have to say yes.
 25 CROSBIE, Q.C.:

Page 245

1 Q. Did Dr. Khalifa know you were using trypsin as
 2 part of your technique?
 3 MR. GULLIVER:
 4 A. Yes. I can't tell you if trypsin was used for
 5 ER/PR. Again I know some antibodies, you use
 6 trypsin digestion, other ones you don't.
 7 CROSBIE, Q.C.:
 8 Q. So you're not sure whether trypsin was used
 9 for ER/PR?
 10 MR. GULLIVER:
 11 A. I can't tell you that. I mean, I didn't do
 12 the procedure. I certainly can find out and
 13 provide information to the Commission.
 14 CROSBIE, Q.C.:
 15 Q. So, Mr. Gulliver, your evidence is that you've
 16 learned, as everyone does, and I guess by the
 17 end of the period to 2005, you knew an awful
 18 lot more about the delicacy of this procedure
 19 than you did at the outset?
 20 MR. GULLIVER:
 21 A. Sure.
 22 CROSBIE, Q.C.:
 23 Q. You had a good understanding of the procedure
 24 by 2005?
 25 MR. GULLIVER:

Page 246

1 A. Yes.
 2 CROSBIE, Q.C.:
 3 Q. That, however, does not seem to be the opinion
 4 of Dr. Carter, does it? Dr. Carter was a
 5 pathologist with special expertise in breast
 6 cancer.
 7 MR. GULLIVER:
 8 A. And that's her opinion, yes.
 9 CROSBIE, Q.C.:
 10 Q. And she thought you did not have a good
 11 understanding of ER/PR testing, as we see at
 12 the letter at 0079, and here in the second
 13 paragraph she says that, "Mr. Terry Gulliver
 14 and Mr. Barry Dyer do not have a good
 15 understanding of the limitations of automated
 16 immunohistochemistry, etc".
 17 MR. GULLIVER:
 18 A. But she's talking about the Ventana system
 19 here now. She's not talking about ER/PR
 20 testing in general. Dr. Carter was not in
 21 favour of the Ventana system of automation.
 22 CROSBIE, Q.C.:
 23 Q. Okay, in the first paragraph she talks about
 24 organizational role in the investigation of
 25 the problems with ER/PR testing from '97 to

Page 247

1 2004, and the planning of solutions to the
 2 current issues discovered with the Ventana
 3 automated system. She seems to be looking at
 4 both things.
 5 MR. GULLIVER:
 6 A. No, specifically here she's talking about she
 7 believed that automation had limitations, and
 8 that's exactly what she's saying there, that
 9 she doesn't think that we have a good
 10 understanding of the limitations of automated
 11 immunohistochemistry.
 12 CROSBIE, Q.C.:
 13 Q. Okay, so you would limit that statement to an
 14 understanding of the Ventana automated system,
 15 not the ER/PR testing generally?
 16 MR. GULLIVER:
 17 A. Exact - well, she doesn't say there "ER/PR
 18 testing".
 19 CROSBIE, Q.C.:
 20 Q. She goes on to say, "Rigorous clinical and
 21 technical validation of antibodies against ER
 22 and PR and establishment of reliable and
 23 reproducible means of providing ER/PR results
 24 to our patients using the substantial
 25 published peer review" and then continuous

Page 248

1 monitoring of immunohistochemical testing
 2 protocol. All that's not limited just to the
 3 Ventana machine surely?
 4 MR. GULLIVER:
 5 A. No, but what she's referring there, by August
 6 1st, '05, since the Ventana system had been
 7 in, Dr. Ejeckam is the director of IHC lab,
 8 Dr. Ejeckam is the one that validated the
 9 antibodies for ER/PR that we were using, so
 10 that was all done under Dr. Ejeckam's
 11 guidance.
 12 CROSBIE, Q.C.:
 13 Q. So, sir, your evidence is that her intent here
 14 was to say that you didn't have a good
 15 understanding of the Ventana automated system?
 16 MR. GULLIVER:
 17 A. Yes.
 18 CROSBIE, Q.C.:
 19 Q. I'd like to go to Document 2095, page 13. I
 20 guess this was advice to Mr. Tilley from Dr.
 21 Williams, who in turn would be relying on
 22 people in pathology and in the lab, and
 23 presumably yourself, for the statement at the
 24 bottom of the page, "It has been determined
 25 that positive controls were conducted every

Page 249

1 day as part of the quality assurance process
 2 within the lab". Were you the source of that
 3 information?
 4 MR. GULLIVER:
 5 A. I could be.
 6 CROSBIE, Q.C.:
 7 Q. And that's what you believe today?
 8 MR. GULLIVER:
 9 A. I believe what today?
 10 CROSBIE, Q.C.:
 11 Q. Positive controls were conducted every day?
 12 MR. GULLIVER:
 13 A. Yes.
 14 CROSBIE, Q.C.:
 15 Q. And these were controls that weren't run
 16 necessarily with each patient slide. They
 17 were run with a batch, right?
 18 MR. GULLIVER:
 19 A. They were run--there were known positive
 20 controls run every single time the ER
 21 procedure was performed. Sometimes there may
 22 be four patient cases in the run with a PR
 23 control, ER control. Other times, there were,
 24 depending on the pathologist who was
 25 interpreting, other times there might have

Page 250

1 been four patient cases in the batch and four
 2 ER controls and four PR controls. It depended
 3 on how many pathologists were doing the
 4 interpretation afterwards. But controls were
 5 run every single time.
 6 CROSBIE, Q.C.:
 7 Q. I thought that you explained earlier in your
 8 testimony that there might only be one control
 9 per batch, even if there were -
 10 MR. GULLIVER:
 11 A. There were times like that, yes.
 12 CROSBIE, Q.C.:
 13 Q. Yes.
 14 MR. GULLIVER:
 15 A. Yeah, but there was a control run every time.
 16 CROSBIE, Q.C.:
 17 Q. Okay. That's the positive external control?
 18 MR. GULLIVER:
 19 A. Yes.
 20 CROSBIE, Q.C.:
 21 Q. And did your lab run negative controls every
 22 day?
 23 MR. GULLIVER:
 24 A. No, we did not.
 25 CROSBIE, Q.C.:

Page 251

1 Q. Because you can't run more--or rather one per
 2 batch as you might be able to do with a
 3 positive control, can you? With negative
 4 controls, you have to run one per patient
 5 sample.
 6 MR. GULLIVER:
 7 A. I think that would be the ideal scenario.
 8 CROSBIE, Q.C.:
 9 Q. Is it more than the ideal scenario? Isn't the
 10 point that it's the patient's own tissue?
 11 MR. GULLIVER:
 12 A. That's a part of the negative control, yes.
 13 Again, you're asking me questions that really
 14 need to be answered by a pathologist.
 15 CROSBIE, Q.C.:
 16 Q. Well, I think we're interested, sir, in
 17 knowing just how much you did understand about
 18 this procedure. So with the negative control,
 19 how is that treated differently than the
 20 patient's specimen which it is intended to be
 21 read for ER/PR status? What's different about
 22 the negative?
 23 MR. GULLIVER:
 24 A. The negative control, when you are applying
 25 the particular antibody that you're trying to

Page 252

1 uncover, investigate, like ER, at that stage
 2 of the procedure, you don't apply any
 3 antibody. It's almost like applying a
 4 placebo, we'd say. But you still treat the
 5 negative slide in all the same other steps of
 6 the procedure.
 7 CROSBIE, Q.C.:
 8 Q. Same in all other respects, except it doesn't
 9 get the antibody?
 10 MR. GULLIVER:
 11 A. Correct.
 12 CROSBIE, Q.C.:
 13 Q. And it's to control for what?
 14 MR. GULLIVER:
 15 A. I think it's mostly used to control when
 16 you're looking at--if you have a positive
 17 external control, you have the patient's own
 18 tissue and the negative control that the
 19 negative control would assist in identifying
 20 background staining or excessive background
 21 staining.
 22 CROSBIE, Q.C.:
 23 Q. So the theory of it, I guess, is that it would
 24 prevent false positives?
 25 MR. GULLIVER:

Page 253

1 A. I don't know if it would prevent false
 2 positives. I think that it would help reduce
 3 false positives.
 4 CROSBIE, Q.C.:
 5 Q. Ideally prevent them, but certainly reduce
 6 them?
 7 MR. GULLIVER:
 8 A. Yeah.
 9 CROSBIE, Q.C.:
 10 Q. Can you explain why negative controls were not
 11 run on a regular basis?
 12 MR. GULLIVER:
 13 A. The decision to use--what controls were run,
 14 it was made by a pathologist. Whether it's
 15 made by the site chief, whether it's made by
 16 the director of that part of the lab, you
 17 know, it's not a technologist's decision.
 18 It's not an administrative decision. Nobody
 19 had requested to run negative controls with
 20 every antibody.
 21 CROSBIE, Q.C.:
 22 Q. So your evidence to the Commission then is
 23 that this was not a technology decision, not a
 24 lab manager decision? It was done under
 25 direction of the pathologists and that the

Page 254

1 decision not to run negative controls, you're
 2 not responsible for that decision?
 3 MR. GULLIVER:
 4 A. No.
 5 CROSBIE, Q.C.:
 6 Q. You agree, your evidence is that you were not
 7 responsible for that decision?
 8 MR. GULLIVER:
 9 A. Right, that was not my decision to make.
 10 CROSBIE, Q.C.:
 11 Q. Did you know there was an issue about negative
 12 controls or even that it's a decision had to
 13 be made?
 14 MR. GULLIVER:
 15 A. I don't think there was ever really much
 16 discussion over negative controls.
 17 CROSBIE, Q.C.:
 18 Q. Was there any?
 19 MR. GULLIVER:
 20 A. During this time frame, Mr. Crosbie, I don't
 21 remember any specific discussion about, you
 22 know, running negative controls with ER/PR or
 23 any other IHC antibodies.
 24 CROSBIE, Q.C.:
 25 Q. Was this a case of not running negative

Page 255

1 controls in order to save money?
 2 MR. GULLIVER:
 3 A. Not to my knowledge, no.
 4 CROSBIE, Q.C.:
 5 Q. Could we go to document 3114, please, page 29?
 6 This is a DAKO handbook you provided over the
 7 weekend. Not this weekend, but the one
 8 before. You see that title there, controls?
 9 MR. GULLIVER:
 10 A. Positive and negative controls, yes.
 11 CROSBIE, Q.C.:
 12 Q. Can you do us the service of reading the first
 13 sentence?
 14 MR. GULLIVER:
 15 A. "Positive and negative controls must be
 16 processed alongside with the unknown to assure
 17 the accuracy of the results in any stain
 18 technique," and this is 1983.
 19 CROSBIE, Q.C.:
 20 Q. Yes. In fact, if we go to page four, that's a
 21 long way back, we'll go there.
 22 THE COMMISSIONER:
 23 Q. Do you want four? The Registrar could get
 24 that.
 25 CROSBIE, Q.C.:

Page 256

1 Q. Yes, that's going to be faster than if I turn
 2 to it. Down at the foot.
 3 THE COMMISSIONER:
 4 Q. The foot of the page, thank you.
 5 CROSBIE, Q.C.:
 6 Q. We see copyright 1983 by DAKO Corporation,
 7 suggesting that this direction or knowledge
 8 about the importance of negative controls goes
 9 back quite a ways.
 10 MR. GULLIVER:
 11 A. Um-hm. Again, you know, negative controls are
 12 used to help assess background staining. Over
 13 the years, this procedure, this test and the
 14 advances made in this test has drastically
 15 reduced background staining in patient slides.
 16 So the requirement for negative controls, if
 17 you check most labs in North America, most
 18 labs don't run negative controls, as this has
 19 advanced. If you actually go read this
 20 manual, back when we first started doing this
 21 procedure, I used to apply glue to glass
 22 slides to try to keep the tissue on, and that
 23 glue would produce a lot of background
 24 staining. So back in the early 80s, it was
 25 more important to run negative controls just

Page 257

1 for the background staining.
 2 When I first started doing this procedure
 3 with Dr. Wang, I used to run negative controls
 4 for the first antibodies. What I would have
 5 to do, I would actually have to go and collect
 6 blood samples from volunteers in the lab and
 7 centrifuge that blood and take the person's
 8 serum, separate it out and add that serum to a
 9 phosphate buffered saline and that was my
 10 placebo that I used to run a negative control
 11 with Dr. Wang. But we did that only for a
 12 short period of time, and -
 13 CROSBIE, Q.C.:
 14 Q. Can I just extract a point here? Are you
 15 saying that it was more important in an
 16 earlier period, in the '80s, to be running
 17 negative controls and it became less important
 18 later?
 19 MR. GULLIVER:
 20 A. No, it became more important when you're
 21 running prognostic markers like ER/PR, but for
 22 general IHC staining, the negative control is
 23 used to look at the amount of background
 24 staining that may be present in that
 25 particular slide.

Page 258

1 CROSBIE, Q.C.:
 2 Q. Now did you just say that most labs don't use
 3 negative controls?
 4 MR. GULLIVER:
 5 A. To my knowledge, a lot of labs do not use--
 6 don't run negative controls with all their IHC
 7 testing.
 8 CROSBIE, Q.C.:
 9 Q. What about ER/PR?
 10 MR. GULLIVER:
 11 A. I can't tell you specifically what every lab
 12 is doing for ER/PR, if they're running both
 13 positive and negative controls, and have
 14 always been running positive and negative
 15 controls.
 16 CROSBIE, Q.C.:
 17 Q. You think there are some credible labs that
 18 don't use negative controls, today, for ER/PR?
 19 MR. GULLIVER:
 20 A. I would submit that you'll probably find that,
 21 yes.
 22 CROSBIE, Q.C.:
 23 Q. Can we go to the Predham answer to
 24 interrogatories 1852, please? This is a
 25 different answer. This is a different

Page 259

1 interrogatory and a different answer from the
 2 one we just looked at, and specifically page
 3 six, please? Question 17 on page six. And so
 4 question 17 asked "please provide a copy of
 5 the bench procedure for antigen retrieval
 6 during the use of the DAKO system" and if we
 7 could then go to page nine, thank you,
 8 Registrar, we see there a spec sheet.
 9 MR. GULLIVER:
 10 A. That looks like it's the ER spec sheet, the
 11 clone.
 12 CROSBIE, Q.C.:
 13 Q. I just have to find my marked up copy. Give
 14 me a moment, please. Down at the bottom of
 15 page nine, I'm going to read a sentence there.
 16 It's like three from the bottom. It says
 17 "there are no obvious signs to indicate
 18 instability of this product. Therefore,
 19 positive and negative controls should be run
 20 simultaneously with patient specimens," and
 21 I'm going to guess that's your writing at the
 22 top of the page.
 23 MR. GULLIVER:
 24 A. That's not my writing, no.
 25 CROSBIE, Q.C.:

Page 260

1 Q. Do you know whose writing it is?
 2 MR. GULLIVER:
 3 A. It looks like to me it's either Mary Butler--I
 4 think Mary Butler.
 5 CROSBIE, Q.C.:
 6 Q. And did you assist Ms. Predham in giving the
 7 answer to this question, "please provide a
 8 copy of the bench procedure for antigen
 9 retrieval during the use of the DAKO system"?
 10 MR. GULLIVER:
 11 A. I think I supplied a--I gave as much
 12 information to Ms. Bussey.
 13 CROSBIE, Q.C.:
 14 Q. And the answer is "please see the bench
 15 procedures for certain clones," and then as
 16 part of the appendix to all that, we have the
 17 spec sheet from DAKO and the statement
 18 "positive and negative controls should be run
 19 simultaneously with patient specimens."
 20 That's not really an equivocal statement, is
 21 it?
 22 MR. GULLIVER:
 23 A. That's their recommendation.
 24 CROSBIE, Q.C.:
 25 Q. It is their recommendation, isn't it?

Page 261

1 MR. GULLIVER:
 2 A. Yeah, and I will submit to you that if the
 3 pathologists want negative controls, they
 4 would have been run. But no pathologist ever
 5 asked to start running negative controls for
 6 IHC testing until recently we're now doing
 7 negative controls.
 8 CROSBIE, Q.C.:
 9 Q. Whose files were these documents in that are
 10 appended here? Were they in any pathologists'
 11 files?
 12 MR. GULLIVER:
 13 A. These were -
 14 CROSBIE, Q.C.:
 15 Q. Or were they in your files?
 16 MR. GULLIVER:
 17 A. They weren't in my files, no. I retrieved
 18 them. I asked the pathology staff to please
 19 gather any documentation. If I got requests
 20 either from, you know, our lawyer's office, I
 21 gathered them up and sent them down to Ms.
 22 Bussey.
 23 CROSBIE, Q.C.:
 24 Q. Is this spec sheet intended for the
 25 pathologist or for the technologist and lab

Page 262

1 manager?
 2 MR. GULLIVER:
 3 A. It's certainly intended for both. There's
 4 information here that applies to both clinical
 5 and technical.
 6 CROSBIE, Q.C.:
 7 Q. Does it imply that negative controls were
 8 mandatory?
 9 MR. GULLIVER:
 10 A. It says that they're recommended.
 11 CROSBIE, Q.C.:
 12 Q. If the purpose of negative controls was to
 13 eliminate or reduce the presence of false
 14 positive readings -
 15 MR. GULLIVER:
 16 A. Which is the background staining, yes.
 17 CROSBIE, Q.C.:
 18 Q. Yes. Does that absence of negative controls
 19 increase the risk of having false positives?
 20 MR. GULLIVER:
 21 A. Again, I think you got to ask the pathologists
 22 that question.
 23 CROSBIE, Q.C.:
 24 Q. Could we go to document 3108, page two? This
 25 document was prepared by you, sir. It's a

Page 263

1 spreadsheet prepared by you?
 2 MR. GULLIVER:
 3 A. Mostly along the way, yes.
 4 CROSBIE, Q.C.:
 5 Q. And it's entitled "ER/PR technical positive
 6 negative rate for St. John's specimens." What
 7 do you mean by technical?
 8 MR. GULLIVER:
 9 A. Technical means if there's something reported
 10 as being positive. So it's not zero, zero.
 11 Someone says it's two percent, five percent,
 12 90 percent, 100 percent, that there is
 13 positive staining detected within the tissue.
 14 CROSBIE, Q.C.:
 15 Q. So what does this table assist us in arriving
 16 at by way of the positivity rate for the total
 17 DAKO period? What do you say it is?
 18 MR. GULLIVER:
 19 A. From a lab perspective, we're saying there
 20 there was 74 percent of the total cases that
 21 were reported as positive staining and 26
 22 percent were reported with zero, zero
 23 staining.
 24 CROSBIE, Q.C.:
 25 Q. Okay, and now you qualify that by saying "from

Page 264

1 a lab perspective." Just explain that.
 2 MR. GULLIVER:
 3 A. Well, if you have, you know, a slide that
 4 comes from the pathology lab and the
 5 pathologist reads the slide and they assign
 6 the case out and says that the tumour cells
 7 are five percent positive for ER/PR or 25
 8 percent positive or 75 percent or 100 percent,
 9 they are saying that there's a portion of that
 10 slide is positive.
 11 CROSBIE, Q.C.:
 12 Q. So in arriving at that 74 percent positivity
 13 rate, you're excluding all the clinically
 14 negative slides?
 15 MR. GULLIVER:
 16 A. Yes.
 17 CROSBIE, Q.C.:
 18 Q. And you think that's the proper way to arrive
 19 at the positivity rate?
 20 MR. GULLIVER:
 21 A. I don't think that there's any proper way and
 22 I think if you search the world, you're
 23 probably not going to find any agreement on
 24 what you should categorize as a positive lab
 25 result or a negative lab result.

Page 265

1 CROSBIE, Q.C.:

2 Q. Well, sir, it sure does produce a different

3 result, I suggest to you, when you include

4 the--when you exclude, rather, the clinically

5 negative and if you go to that column, total

6 DAKO, over toward the right, rather, you count

7 down three lines, you got 53 percent, and I

8 suggest to you that that's the true positivity

9 rate for the total DAKO period.

10 MR. GULLIVER:

11 A. That's 53 percent of what we call strong

12 positive.

13 CROSBIE, Q.C.:

14 Q. And that's the most appropriate way of doing

15 the calculation is your evidence? That's what

16 you feel is most appropriate way? The way

17 that arrives at 74 percent, that's the most

18 appropriate way?

19 MR. GULLIVER:

20 A. No, that's why I have three different figures

21 here. When this was being done along the way

22 within Eastern Health, there was still no

23 agreement upon between the lab side and the

24 oncologists side of what really constituted a

25 positive or a negative. We heard people say

Page 266

1 that anything above one percent should be

2 considered positive. So that's why I made

3 three separate categories, so we could make

4 that determination. What percentage were

5 strong positives, there's no dispute. They're

6 positive, positive, positive. What numbers

7 and percentage would fall into that, the

8 clinical definition and what ones were the

9 true zero, zeros, the true negatives, and if

10 you look at that figure, you can see there's

11 a--you just showed the total, 53 percent were

12 strongly positive. 19 percent were reported

13 with a degree with positivity and there were

14 28 percent that were reported with no staining

15 whatsoever.

16 CROSBIE, Q.C.:

17 Q. Can we go to document 3100, please, Registrar?

18 It's an e-mail on October '07 from you to Dr.

19 Howell and some others, and it's about the

20 Peninsula results and you say "please find

21 attached a table of the Peninsulas' patients

22 who originally tested at MSH from 1999-2005"

23 and that must mean Mount Sinai, correct?

24 MR. GULLIVER:

25 A. Yes.

Page 267

1 CROSBIE, Q.C.:

2 Q. "I read each hard copy of reports and then

3 logged them the same as we did two years ago."

4 Then you say "positive, weak positive and

5 negative, no staining, the positive negative

6 rate overall is excellent," and if we look

7 down to the table, which is page two, we see a

8 78.3 percent positivity rate, which in fact is

9 excellent, isn't it?

10 MR. GULLIVER:

11 A. Um-hm.

12 CROSBIE, Q.C.:

13 Q. However, you--did you ever meet with Dr. Gown?

14 MR. GULLIVER:

15 A. I never met with him. I was in a room where

16 he was there.

17 MR. SIMMONS:

18 Q. Excuse me, I think there's nowhere in this

19 report any questions concerning the content

20 from Dr. Gown, I believe that's a matter that

21 we haven't (inaudible).

22 THE COMMISSIONER:

23 Q. Whether he met with him or not surely isn't

24 the question, and so far Mr. Crosbie hasn't

25 trespassed into anything that could be

Page 268

1 classified as solicitor-client privilege, I

2 don't think.

3 MR. SIMMONS:

4 Q. (Inaudible).

5 CROSBIE, Q.C.:

6 Q. Well, I don't need a reminder because--maybe

7 my friend needs a reminder that Dr. Gown swore

8 an affidavit, and in that affidavit, he quoted

9 a 74 percent positivity rate. We can look at

10 the affidavit, if you wish. I'm just--I'm

11 suggesting that must have come from you.

12 MR. GULLIVER:

13 A. I think that came probably from some of those

14 tables that I was asked to produce and update

15 over the period of time.

16 CROSBIE, Q.C.:

17 Q. So you feel that information must have come

18 from you, 74 percent?

19 MR. GULLIVER:

20 A. I don't know must have. I didn't give it to

21 him directly, but whoever gave it to him

22 probably used that as a source for their

23 estimation.

24 CROSBIE, Q.C.:

25 Q. Why did you use a different method of

Page 269

1 calculating the positivity rate for
 2 Clarenville than you did for St. John's?
 3 MR. GULLIVER:
 4 A. How is there a different method? I got
 5 positives, the weak positives and then the
 6 zero, the negative no staining.
 7 CROSBIE, Q.C.:
 8 Q. All right, let's put it this way, if we follow
 9 the same method you followed at Exhibit 3100
 10 for Clarenville, who we know was sending
 11 their--past a certain point, their material
 12 out to Mount Sinai, we get 78.3 percent
 13 positivity. That's obvious. If we follow the
 14 same methodology for St. John's, we get 53
 15 percent positivity, the same methodology.
 16 MR. GULLIVER:
 17 A. Again, this is a total of 112 specimens. The
 18 numbers here is a total of 143 cases that were
 19 reviewed for Peninsulas.
 20 CROSBIE, Q.C.:
 21 Q. Yes. So that's not big enough to have a--run
 22 a valid estimate of positivity rates?
 23 MR. GULLIVER:
 24 A. I don't know that, but I didn't do this to
 25 determine the positive, negative rates for

Page 270

1 Clarenville. That's not why this was done.
 2 CROSBIE, Q.C.:
 3 Q. Okay. Well, we just take the same methodology
 4 which yields 78.3 percent and we do it with
 5 St. John's and it yields 53 percent. We're
 6 agreed on that?
 7 MR. GULLIVER:
 8 A. The strong positives, yes.
 9 CROSBIE, Q.C.:
 10 Q. Yet 53 percent doesn't find its way into Dr.
 11 Gown's affidavit. It's 74 percent.
 12 MR. GULLIVER:
 13 A. Again, I did not give him anything directly.
 14 CROSBIE, Q.C.:
 15 Q. Never met with him?
 16 MR. GULLIVER:
 17 A. I was in a room where he was in attendance. I
 18 never met with him individually, separately,
 19 no.
 20 CROSBIE, Q.C.:
 21 Q. Suggest to you that the Clarenville positivity
 22 rates are a reasonable control for positivity
 23 in St. John's, done at Mount Sinai.
 24 THE COMMISSIONER:
 25 Q. I'm sorry, the question, I didn't understand

Page 271

1 the question, Mr. Crosbie.
 2 CROSBIE, Q.C.:
 3 Q. I'm suggesting to the witness that this
 4 positivity result for Clarenville is a
 5 reasonable control for what was being done in
 6 St. John's at the same point in time.
 7 MR. GULLIVER:
 8 A. I don't understand.
 9 THE COMMISSIONER:
 10 Q. Control or comparable?
 11 CROSBIE, Q.C.:
 12 Q. Pardon me?
 13 THE COMMISSIONER:
 14 Q. I mean, in the--I think it's the use of the
 15 word "control" that I'm having trouble with.
 16 CROSBIE, Q.C.:
 17 Q. Well -
 18 THE COMMISSIONER:
 19 Q. Are you suggesting they should have had the
 20 same -
 21 CROSBIE, Q.C.:
 22 Q. For the same reason that you keep tabs on your
 23 positivity rate, it's a metric that tells you
 24 whether you're conforming to established
 25 expectations in your outcomes. So sir, I'm

Page 272

1 simply suggesting that this is an interesting
 2 and valid control against what was going on at
 3 your lab in St. John's.
 4 MR. GULLIVER:
 5 A. Well, you haven't even asked me why I even did
 6 this.
 7 CROSBIE, Q.C.:
 8 Q. Can you answer the question, please?
 9 MR. GULLIVER:
 10 A. I can't answer your question because you're
 11 assuming--I think you're trying to infer that
 12 this was done to compare the St. John's
 13 testing to a pool of results that we could
 14 access in Clarenville that were done at Mount
 15 Sinai and compare the two from St. John's to
 16 Clarenville.
 17 CROSBIE, Q.C.:
 18 Q. During the same time period, yes.
 19 MR. GULLIVER:
 20 A. This was done just quite recently, the
 21 Clarenville ones. Long after all of our
 22 retesting was completed.
 23 CROSBIE, Q.C.:
 24 Q. Would you go back to page one there? What
 25 you're saying there is these were tested at

Page 273

1 Mount Sinai from 1999 to 2005.
 2 MR. GULLIVER:
 3 A. Right, but I did this in October of 2007, long
 4 after our retesting was pretty well completed
 5 at Mount Sinai. This was not done to compare
 6 St. John's results to somehow Mount Sinai
 7 results.
 8 CROSBIE, Q.C.:
 9 Q. No, it doesn't matter why you did it. I'm
 10 saying there's the data. When we compare the
 11 two, for the same--more or less the same
 12 periods, your calculations yield, done by the
 13 same methodology, 53 percent positivity in St.
 14 John's, and yet in Clarenville, sending their
 15 specimens to Mount Sinai, they got 78 percent.
 16 MR. GULLIVER:
 17 A. On 143 samples over almost six years. But the
 18 main reason why we did this here was that
 19 every patient with a test performed in
 20 Newfoundland had the review done to see if
 21 they should be retested at Mount Sinai, and
 22 the assumption was made that the patients who
 23 resided on the Clarenville domain and had been
 24 tested at Mount Sinai from '99 up until this
 25 point in time, that the assumption was that

Page 274

1 any negative patients there could not retest
 2 positive and should those patients be given
 3 the same review as all the other patients in
 4 Newfoundland. It had nothing to do with
 5 trying to compare positive rates to what was
 6 found in St. John's.
 7 CROSBIE, Q.C.:
 8 Q. That may be so. Could the reason for the
 9 difference in performance on this metric,
 10 positivity rates, be poor quality tissue
 11 preparation and lack of controls?
 12 MR. GULLIVER:
 13 A. Lack of controls at St. John's? I don't think
 14 so. Controls were run every time in St.
 15 John's, but it certainly could be due to--
 16 partly due to tissue preparation. I mean,
 17 that's obviously one of the factors that could
 18 affect the outcome.
 19 CROSBIE, Q.C.:
 20 Q. Could we go to 2141, please? And I read
 21 there, March 6th, 2006. Now this is a note by
 22 Dr. Cook but he's speaking to Dr. Naghibi why
 23 Clarenville discontinued ER/PR slides. She
 24 replied "it was due to poor quality and to
 25 lack of external controls." That's what they

Page 275

1 thought in Clarenville.
 2 MR. GULLIVER:
 3 A. And plus, they were paying for this.
 4 CROSBIE, Q.C.:
 5 Q. That's what they thought in Clarenville.
 6 MR. GULLIVER:
 7 A. And I think that was during a time after Dr.
 8 Khalifa stopped all the interpretations.
 9 There were control slides that were run and
 10 the control slide was being read and verified
 11 pathologists in St. John's and then cases--
 12 then the slides were--the patient slides were
 13 sent out to around the region. That went on
 14 for a small time frame before control slides
 15 were done for every pathologist that were
 16 outside St. John's interpreting.
 17 CROSBIE, Q.C.:
 18 Q. I put it to you that this suggests that
 19 positive controls were not being conducted
 20 every day.
 21 MR. GULLIVER:
 22 A. Well, I'm telling you that's not correct.
 23 CROSBIE, Q.C.:
 24 Q. Thank you. Now could we have the testimony of
 25 Dr. O'Malley? It's June 23, 2008, page 179.

Page 276

1 REGISTRAR:
 2 Q. June 23rd?
 3 CROSBIE, Q.C.:
 4 Q. That's what my note says, June 23rd. And page
 5 179. Let's see if we are where I think we
 6 are. Yes. Could you just read that passage,
 7 roughly lines one to 17 at the top of page
 8 179? Just read it to yourself.
 9 MR. GULLIVER:
 10 A. On the right-hand side?
 11 CROSBIE, Q.C.:
 12 Q. On the right-hand side, that's page 179. Just
 13 read it to yourself. Whenever you're ready,
 14 sir.
 15 MR. GULLIVER:
 16 A. Go ahead.
 17 CROSBIE, Q.C.:
 18 Q. So the first point I'd extract out of that is
 19 "a good control should catch problems in the
 20 preparation of specimens." Nothing
 21 controversial about that.
 22 MR. GULLIVER:
 23 A. And I don't know if he means the internal or
 24 external control.
 25 CROSBIE, Q.C.:

Page 277

1 Q. The second point is that "the effectiveness of
 2 controls depends on having a senior,
 3 experienced technologist or pathologist to
 4 oversee the technical steps." Anything
 5 controversial about that?
 6 MR. GULLIVER:
 7 A. No.
 8 CROSBIE, Q.C.:
 9 Q. So if she's describing, it's she, is
 10 describing a critical function in ensuring a
 11 quality test, senior supervision and
 12 oversight.
 13 MR. GULLIVER:
 14 A. Yeah.
 15 CROSBIE, Q.C.:
 16 Q. And on the technical side, you said that the
 17 persons performing that critical function in
 18 the period from 1997 to 2005 were who again?
 19 MR. GULLIVER:
 20 A. Well, from 1987 up until -
 21 CROSBIE, Q.C.:
 22 Q. '97.
 23 MR. GULLIVER:
 24 A. But from '87, Mary Butler and Peggy Welsh are
 25 doing IHC testing. Then they're the two ten

Page 278

1 years later who start doing the ER/PR testing
 2 with Dr. Khalifa. They continue that up until
 3 Mr. Ken Green, who was 25 years in pathology
 4 at St. Clare's. He moves in as a third
 5 technologist in the IHC lab. Ms. Welsh
 6 resigns and she moves to Nova Scotia and then
 7 the next senior pathology technologist, Mr.
 8 Les Simms, was then moved into that part of
 9 the laboratory.
 10 CROSBIE, Q.C.:
 11 Q. And you as manager were responsible to ensure
 12 that they were doing that function that Dr.
 13 O'Malley describes here?
 14 MR. GULLIVER:
 15 A. I was the manager up until 2001 when Mary and
 16 Peggy were both there as technologists.
 17 CROSBIE, Q.C.:
 18 Q. And in the period until 2001, the answer then
 19 would be "yes"?
 20 MR. GULLIVER:
 21 A. Up until 2001?
 22 CROSBIE, Q.C.:
 23 Q. When you moved? The answer then would be
 24 "yes"?
 25 MR. GULLIVER:

Page 279

1 A. I was the manager then, yes.
 2 CROSBIE, Q.C.:
 3 Q. And you were responsible to ensure that these
 4 people were doing - were performing that
 5 critical function?
 6 MR. GULLIVER:
 7 A. And to the best of my knowledge, they
 8 performed that function.
 9 CROSBIE, Q.C.:
 10 Q. Your answer then is "yes"?
 11 MR. GULLIVER:
 12 A. The technologists?
 13 CROSBIE, Q.C.:
 14 Q. No, no, I asked you, you were responsible as
 15 manager?
 16 MR. GULLIVER:
 17 A. well, at that time I'm managing pathology,
 18 blood collection, immunology. I probably got
 19 75 staff, and I said to you earlier I cannot
 20 be behind staff shoulders 24 hours a day, 7
 21 days a week. There's a point where you have
 22 trained staff where you expect that they will
 23 perform their job as they're supposed to.
 24 CROSBIE, Q.C.:
 25 Q. So is the answer then that no one was

Page 280

1 exercising managerial oversight over their
 2 fulfilment of those responsibilities?
 3 MR. GULLIVER:
 4 A. No, that's not the answer.
 5 CROSBIE, Q.C.:
 6 Q. Then is the answer that sometimes you did and
 7 sometimes you didn't?
 8 MR. GULLIVER:
 9 A. No, I think the answer is that people work,
 10 they do their jobs, they work independently in
 11 a lot of these parts of the laboratories. If
 12 they needed guidance or assistance, they would
 13 go to the pathologist if it's a clinical
 14 issue. If they needed guidance or assistance
 15 for an administrative issue, then they would
 16 go to their direct manager, and at that point
 17 in time it would be me.
 18 CROSBIE, Q.C.:
 19 Q. So the system was if they had a problem, they
 20 should come to somebody else?
 21 MR. GULLIVER:
 22 A. If they had a problem that they needed
 23 assistance with, then they would go seek
 24 guidance.
 25 CROSBIE, Q.C.:

Page 281

1 Q. And if they had a problem and didn't know it,
 2 then I guess they wouldn't go and seek
 3 guidance?
 4 MR. GULLIVER:
 5 A. Well, if they had a problem and didn't know
 6 it, that problem should show up in the end
 7 product, which is the slide, and then the
 8 pathologist would still read every single
 9 slide and sign it out and verify it, so they
 10 would pick up a problem.
 11 CROSBIE, Q.C.:
 12 Q. Looking at line 15 on page 181, "So if it
 13 turns out that an institution was not getting
 14 reliable reading of the patient's tissue
 15 sample, it stands to reason we should look for
 16 problems with the controls", and she says,
 17 "Definitely, yes". Do you agree, disagree?
 18 MR. GULLIVER:
 19 A. I never heard her testimony, or don't know how
 20 this is all framed here, but certainly with
 21 that simple statement, I would have to say
 22 yes. I'm thinking she's wanting to talk about
 23 the internal patient's control. She's talking
 24 about reading the patient's tissue sample.
 25 CROSBIE, Q.C.:

Page 282

1 Q. Could we go to the testimony of Dr. Cook, July
 2 7th, 2008, page 218. What I'm asking Dr. Cook
 3 about right there in that paragraph starting
 4 around line six -
 5 MR. GULLIVER:
 6 A. Over on page 218?
 7 CROSBIE, Q.C.:
 8 Q. Right. There was testimony from a Dr. Mullen
 9 from Mount Sinai earlier, and he looked at his
 10 data and he - depending on what values you use
 11 for clinically positive/clinically negative,
 12 then his positivity rate for the material he
 13 had processed on behalf of Eastern Health here
 14 would vary between 46.3 and 53.7 percent
 15 positivity rate, and I was putting that to Dr.
 16 Cook, and Dr. Cook, you might see at 219, page
 17 219, "No, it's more - it's in the range of 70
 18 to 67 percent - 67 to 70 percent positivity,
 19 30 to 33 percent negative". He's disagreeing,
 20 in other words, and I'm suggesting it would
 21 look like he's getting that information from
 22 you?
 23 MR. GULLIVER:
 24 A. I have never said directly to Dr. Cook - again
 25 you've seen multiple times where that

Page 283

1 spreadsheet was updated. You've seen the
 2 template, and I mean, Dr. Cook would have a
 3 copy of it and he could use it as he - and
 4 that's his opinion.
 5 CROSBIE, Q.C.:
 6 Q. Do you have a view, Mr. Gulliver, on who's
 7 correct, Dr. Mullen or Dr. Cook? Was it more
 8 in the area of 50 percent or 30 percent?
 9 MR. GULLIVER:
 10 A. About positive cases?
 11 CROSBIE, Q.C.:
 12 Q. Well, 30 percent would refer to the negative
 13 rate.
 14 MR. GULLIVER:
 15 A. I think that our negative rate is closer to
 16 the 30 percent.
 17 CROSBIE, Q.C.:
 18 Q. So what is the - you're program director now.
 19 What is the laboratory's position on the
 20 positivity rate for the period of the DAKO
 21 machine, what is your position?
 22 MR. GULLIVER:
 23 A. I don't think Eastern Health has a position on
 24 that.
 25 CROSBIE, Q.C.:

Page 284

1 Q. All this time later?
 2 MR. GULLIVER:
 3 A. Are you asking my opinion or are you asking
 4 what's Eastern Health's position on the
 5 overall positivity rate?
 6 CROSBIE, Q.C.:
 7 A. Well, both. If your opinion is different from
 8 something you know to be the official view of
 9 Eastern Health, you can let us know about it,
 10 but let's come back to your answer, you're not
 11 sure that Eastern Health has a position on
 12 what its positivity rate was during the
 13 relevant period?
 14 MR. GULLIVER:
 15 A. I don't think Eastern Health has done an
 16 official release of data to say here was the
 17 official positivity rate. Again you're going
 18 back to a debate that's been going on for a
 19 long time, not just in Eastern Health, across
 20 a lot of labs, in what really is the
 21 definition of a positive, what's a positive,
 22 what's a negative.
 23 CROSBIE, Q.C.:
 24 Q. And so you can't give us the position of
 25 Eastern Health on that question?

Page 285

1 MR. GULLIVER:
 2 A. I can't, no.
 3 CROSBIE, Q.C.:
 4 Q. Thank you. I'd like to go back to these
 5 Ejeckam memos, 113, page 5. I'm just looking
 6 for my paper copy because I have it marked.
 7 Yes, it's page 5 of 113. So just to pick a
 8 few things out of there we can note - now,
 9 first of all, this is the third memorandum,
 10 June 19th, 2003. The earlier one, which you
 11 can look at if you want to, but you've
 12 probably seen it lots of times, it's at page
 13 one, and it's April of 2003. That's the first
 14 one and it was addressed to pathologists and
 15 Barry Dyer, and all technical staff on
 16 immunohistochemistry.
 17 MR. GULLIVER:
 18 A. It's addressed to pathologists across the
 19 province, and it's cc'd to --
 20 CROSBIE, Q.C.:
 21 Q. CC'd, yeah.
 22 MR. GULLIVER:
 23 A. To Barry and the technical staff in the IHC
 24 lab.
 25 CROSBIE, Q.C.:

Page 286

1 Q. So your evidence would be that this wasn't
 2 sent to you and it didn't find its way into
 3 your hands?
 4 MR. GULLIVER:
 5 A. I found out from Mr. Dyer after the fact,
 6 after testing had been stopped.
 7 CROSBIE, Q.C.:
 8 Q. So then if we go to the next one, we see May
 9 2nd, 2003. This one is to pathologists -
 10 MR. GULLIVER:
 11 A. It's the same group as the other one, and I
 12 think it's CC'd to Mr. Dyer and technical
 13 staff.
 14 CROSBIE, Q.C.:
 15 Q. Yes, same as before. So that's why I'm going
 16 to ask you why the difference when we get to
 17 June? That's addressed to you.
 18 MR. GULLIVER:
 19 A. Again I've said in my testimony with Ms.
 20 Chaytor that - and this takes place - it's
 21 seven weeks after he puts testing back in
 22 place. I had met Dr. Ejeckam over in the lab
 23 corridor and I had said to him that if there's
 24 anything else that he views in the IHC part of
 25 our lab, you know, put it in writing and send

Page 287

1 it to me, and that's why - and there's been
 2 some dispute over did I even ask him to do
 3 that, and, you know, my point is I'm the only
 4 one who gets addressed this one. He doesn't
 5 send the memo shutting down testing, he
 6 doesn't send me the memo putting testing back
 7 in place, but he - I'm the only one who he's
 8 addressed this to, and he copies the clinical
 9 chief, and I think Dr. Robb, but he addressed
 10 this one specifically to me because I asked
 11 him any else with the lab, put it in writing,
 12 and then we sat down and we talked about it.
 13 CROSBIE, Q.C.:
 14 Q. Could it be because you had budgetary
 15 responsibility?
 16 MR. GULLIVER:
 17 A. I think that's a part of my role, yes.
 18 CROSBIE, Q.C.:
 19 Q. Well, let's look at what he's saying here.
 20 Paragraph one, he's talking about physical
 21 location. Paragraph three, he's talking about
 22 the need for a dedicated staff. Over on page
 23 two down toward the bottom of the paragraph,
 24 he's talking about to do less would become a
 25 gamble where you may win or lose?

Page 288

1 MR. GULLIVER:
 2 A. Uh-hm.
 3 CROSBIE, Q.C.:
 4 Q. And talks about spelling disaster, and bottom
 5 of page - paragraph four, he talks about an
 6 activity being identified as special and
 7 unique and requiring financing and staffing.
 8 At paragraph six -
 9 MR. GULLIVER:
 10 A. The next paragraph he compliments our existing
 11 staff.
 12 CROSBIE, Q.C.:
 13 Q. Yes, he does, and in paragraph six, he speaks
 14 of diagnosis and so on, jeopardizing patient
 15 care, and at the bottom he says, "Therefore,
 16 advise you kindly take a hard look and then
 17 commit the necessary resources, human and
 18 financial, to this special all important and
 19 only service", and you described for us
 20 earlier how your responsibility had to do with
 21 budgeting and making sure that what was being
 22 done was adequately budgeted for?
 23 MR. GULLIVER:
 24 A. That's a part of my overall responsibility as
 25 the program director.

Page 289

1 CROSBIE, Q.C.:

2 Q. Sir, we know that this didn't find its way to

3 Dr. Williams, did it?

4 MR. GULLIVER:

5 A. Not to my knowledge, no.

6 CROSBIE, Q.C.:

7 Q. Until much later.

8 MR. GULLIVER:

9 A. Yeah.

10 CROSBIE, Q.C.:

11 Q. If human and financial resources had to be

12 committed, that by itself would mean that this

13 would have to go to Dr. Williams?

14 MR. GULLIVER:

15 A. If we had to find - if we had to ask for new

16 resources or additional resources.

17 CROSBIE, Q.C.:

18 Q. When I read this, it sure looks to me like Dr.

19 Ejeckam thinks that necessary human and

20 financial resources be committed, meaning new

21 ones. You had a different view?

22 MR. GULLIVER:

23 A. No, I sat down with Dr. Ejeckam and we

24 discussed all parts of this here, and I've

25 testified, as you probably read or heard, what

Page 290

1 we did in response to this here for Dr.

2 Ejeckam. It was physically moving the staff

3 and the lab into its own dedicated space,

4 which did not require new additional

5 resources. We took the current staff that

6 were working in the IHC lab with Dr. Ejeckam.

7 He wanted them to be full time in the lab to

8 spend more time with him for training and

9 read, as he says - as he outlines there. I

10 think Mr. Dyer took one of the technologists

11 from St. Clare's, moved them over to Health

12 Sciences to train them in to do the small

13 grossing to replace part of the work these

14 people were doing, and then the advancement in

15 the new technology, new equipment to help with

16 workload and productivity and volumes, I've

17 already testified we had enough money in our

18 operating budget to be able to go out and

19 acquire the Ventana system within existing

20 resources. So I didn't need to go to Dr.

21 Williams to look for new resources for this

22 here.

23 CROSBIE, Q.C.:

24 Q. Commissioner, I'll no longer be critical of

25 Ms. Chaytor for going longer than her

Page 291

1 estimated time. I still have a fair amount of

2 material here.

3 THE COMMISSIONER:

4 Q. Do you want to take the afternoon break?

5 CROSBIE, Q.C.:

6 Q. Probably a good place.

7 (BREAK)

8 THE COMMISSIONER:

9 Q. Please be seated. Mr. Crosbie.

10 CROSBIE, Q.C.:

11 Q. Thanks. Registrar, could we have Dr. Cook's

12 testimony, July 2nd, 2008, page 262. What I'm

13 asking Dr. Cook about there is the follow-up

14 to the Ejeckam memorandum, and as we've just

15 seen, the memorandum in June addressed to you

16 had recommendations for various forms of

17 action, Mr. Gulliver, including mention of

18 resources that should be committed, and so I'm

19 just going to ask you to have a look at Dr.

20 Cook's account. You can take your mouse there

21 if you would, and go from page 262 to 265.

22 Read that to yourself, and when you're through

23 I'm going to ask you if his account squares

24 with your recollection of how this transpired.

25 I might have said I asked the questions, but

Page 292

1 it's obviously Mr. Coffey.

2 MR. GULLIVER:

3 A. You want me to go to the end of 265?

4 CROSBIE, Q.C.:

5 Q. Well, 265 is probably - that tells the story.

6 MR. GULLIVER:

7 A. Okay.

8 CROSBIE, Q.C.:

9 Q. And you notice at line 11, 265, Dr. Cook -

10 well, he was asked just before that why he

11 wouldn't have spoken to Dr. Ejeckam about it.

12 He said, "Because I felt an agreement or

13 understanding had been made with Mr. Gulliver

14 to address his concerns". First of all, can

15 you tell the Commissioner whether this seems

16 like a fair account of what transpired in

17 relation to whatever meeting you had about Dr.

18 Cook and the question of following up on Dr.

19 Ejeckam's concerns?

20 MR. GULLIVER:

21 A. I think that's a fair account, that after Dr.

22 Ejeckam and I and Barry had met in my office

23 and talked about, you know, June 19th memo,

24 and the things that we could do, the time

25 frame that it would take, I think Dr. Cook and

Page 293

1 I just spoke about it, and I let Dr. Cook know
 2 what we had talked about, and I think this is
 3 a fairly accurate account of what transpired.
 4 CROSBIE, Q.C.:
 5 Q. So what I get out of that is that the follow-
 6 up was informal in the sense there's nothing
 7 in writing?
 8 MR. GULLIVER:
 9 A. Yes.
 10 CROSBIE, Q.C.:
 11 Q. Was there further oral communication between
 12 you and Dr. Cook on the response to Dr.
 13 Ejeckam's concerns?
 14 MR. GULLIVER:
 15 A. Not specifically. I just think that over a
 16 time period, I think that both Dr. Cook and I
 17 saw that, you know, the laboratory itself was
 18 moving into its own space, knew that Mr. Dyer
 19 had start putting a process in place to
 20 retrain other techs in pathology to take over
 21 the grossing function that the IHC techs were
 22 taking, thereby freeing them up to have more
 23 time down in the IHC lab, and I think that Dr.
 24 Cook knew - and this happened in late June.
 25 Again it's during the summer period with

Page 294

1 vacations and things, and then I think in
 2 September Mr. Dyer starts writing the tender
 3 to go out to the marketplace looking for a new
 4 system.
 5 CROSBIE, Q.C.:
 6 Q. But there's no oral communication about the
 7 progress of this between you and Cook, is
 8 there?
 9 MR. GULLIVER:
 10 A. I don't think we had a separate meeting about
 11 it, just thinking in just talking -
 12 CROSBIE, Q.C.:
 13 Q. Oral communication.
 14 MR. GULLIVER:
 15 A. In speaking to Dr. Cook, yes.
 16 CROSBIE, Q.C.:
 17 Q. You did speak to him about the progress of
 18 these matters?
 19 MR. GULLIVER:
 20 A. To my knowledge, yes.
 21 CROSBIE, Q.C.:
 22 Q. Okay, nothing in writing, though, is there?
 23 MR. GULLIVER:
 24 A. No.
 25 CROSBIE, Q.C.:

Page 295

1 Q. There's no actual appraisal of what would be
 2 acted on and what would not be acted on?
 3 MR. GULLIVER:
 4 A. In relation to what we could do?
 5 CROSBIE, Q.C.:
 6 Q. In relation to what Dr. Ejeckam set out as
 7 being his concerns.
 8 MR. GULLIVER:
 9 A. Well the concerns were the space, the staffing
 10 being dedicated and then to address the
 11 workload volumes and productivity.
 12 CROSBIE, Q.C.:
 13 Q. There was no budget drawn up because you
 14 didn't see those issues or any other issues
 15 raised by Ejeckam as requiring a commitment of
 16 fresh resources.
 17 MR. GULLIVER:
 18 A. It didn't seem to be at the time, no.
 19 CROSBIE, Q.C.:
 20 Q. And overall, you and Dr. Cook regarded the
 21 issues raised by Dr. Ejeckam as among a host
 22 of other issues of similar importance facing
 23 the lab, the lab program?
 24 MR. GULLIVER:
 25 A. I would say yes.

Page 296

1 CROSBIE, Q.C.:
 2 Q. And the Ejeckam issues deserved no special
 3 attention and no documentation of a special
 4 nature and no special reporting?
 5 MR. GULLIVER:
 6 A. I think they required the attention that we
 7 gave them in talking to Dr. Ejeckam. Dr.
 8 Ejeckam seen the physical things that were
 9 taking place and, you know, what we committed
 10 to, it actually all took place.
 11 CROSBIE, Q.C.:
 12 Q. In your opinion, did Dr. Cook provide
 13 appropriate leadership on the Ejeckam issues?
 14 MR. GULLIVER:
 15 A. I really don't think I could answer that. I
 16 think that from my perspective, what was in my
 17 realm of responsibility, talking about the
 18 space, staff and equipment, that I think I
 19 responded appropriately, along with Mr. Dyer
 20 in conjunction with Dr. Ejeckam and Dr. Cook
 21 was well aware of the things that were taking
 22 place.
 23 CROSBIE, Q.C.:
 24 Q. I'd like to turn now to the question of some
 25 statistics and I mentioned earlier about the

Page 297

1 Gown affidavit and that's found at P-0375,
 2 page 2 if the Registrar can take us there,
 3 please? And page 2, paragraph 6, and that's
 4 the reference there, "In reviewing the generic
 5 data presented to me, it appeared that the ER
 6 positivity rate was in the range of 65 to 75
 7 percent for breast cancers analyzed at the
 8 laboratory during the time the DAKO instrument
 9 was employed. I have been advised that the
 10 seven year average was 74 percent ER
 11 positivity." And that information would seem
 12 to be in sync with what you developed in your
 13 spreadsheets?
 14 MR. GULLIVER:
 15 A. Probably, yes.
 16 CROSBIE, Q.C.:
 17 Q. Could we now bring up Exhibit P-1841? This is
 18 explained in the footnotes, Mr. Gulliver. It
 19 was prepared by Dr. Hutton and it's based on
 20 information contained in those
 21 interrogatories, the documents which we looked
 22 at a little earlier. And it's simply a matter
 23 of taking numbers and doing a little math on
 24 them and arriving at percentages, and you'll
 25 see in that top table there where Dr. Hutton

Page 298

1 simply takes total test, total positives and
 2 any of us could take the same information from
 3 the Predham answers to interrogatories and do
 4 the same calculations. We come up with a
 5 calculation of a false negative rate and
 6 percentage terms, and for the period in the
 7 top table, the period when the DAKO
 8 autostainer was in use, the statistical
 9 performance shows a 44 percent false negative
 10 rate. Are you in any position to dispute
 11 that?
 12 MR. GULLIVER:
 13 A. I'm really in no position to either agree or
 14 disagree. This is the first time I've seen
 15 this kind of analysis.
 16 CROSBIE, Q.C.:
 17 Q. Have you calculated the false negative rate?
 18 MR. GULLIVER:
 19 A. No, I have not.
 20 CROSBIE, Q.C.:
 21 Q. Nobody asked you to do that?
 22 MR. GULLIVER:
 23 A. I think that's a part of what NLCHI has been
 24 working on and doing some analyses.
 25 CROSBIE, Q.C.:

Page 299

1 Q. So that was left for NLCHI to do.
 2 MR. GULLIVER:
 3 A. And I guess it looks like to me if you're
 4 using the clinical guidelines as to what's a
 5 negative and positive for this table, on the
 6 bottom it says "30 percent cut off and 10
 7 percent".
 8 CROSBIE, Q.C.:
 9 Q. Yes. Clinically negative. I want to come
 10 back to--so just to get that clear now,
 11 Eastern Health as far as you're aware doesn't
 12 have a calculation or an official position on
 13 what a false negative rate was.
 14 MR. GULLIVER:
 15 A. No, I think that NLCHI is doing some of that
 16 analyses in the database and I think they're
 17 doing it, Mr. Crosbie, based upon a one
 18 percent positivity, which would be, you know,
 19 a positive result, but at one percent, ten
 20 percent, 30 percent, looking at different cut
 21 offs.
 22 CROSBIE, Q.C.:
 23 Q. Well I'm sure that will be revealed to us all
 24 in good time. I want to come to your--when
 25 you were talking to Ms. Chaytor and it was in

Page 300

1 relation to this NTV story from October 13th,
 2 2005, you know the one that talked about new
 3 technology with more accurate results and 90
 4 to 95 percent of patients won't be affected
 5 and all testing would be complete in a month,
 6 that one?
 7 MR. GULLIVER:
 8 A. Yeah.
 9 CROSBIE, Q.C.:
 10 Q. You adopted the approach of talking about 3000
 11 patients, meaning, I guess, 3000 patients who
 12 had been, on whom this test had been run in
 13 the period '97 through 2005.
 14 MR. GULLIVER:
 15 A. Well I think at that time, but that time, I
 16 think that's October '05, I think that the day
 17 that we had available at that time was that I
 18 had seen through the computer searches that we
 19 searched for ER/PR tests and there were
 20 approximately 3000 tests that were performed.
 21 CROSBIE, Q.C.:
 22 Q. Uh-hm. How does that relate to what we looked
 23 at in Exhibit P-3107 this morning at page 2
 24 where the number 2700 and 26 appears?
 25 MR. GULLIVER:

Page 301

1 A. Again, this here has been refined many times,
 2 this is dated January of '08, I think, over
 3 three years later. And by this time we've
 4 gone back through all the reports and verified
 5 and patients who had ER/PR tests performed
 6 that weren't on the primary breast cancers
 7 were removed from the--from numbers.
 8 CROSBIE, Q.C.:
 9 Q. Uh-hm, so you know, are we talking about
 10 twenty seven hundred and something patients?
 11 MR. GULLIVER:
 12 A. Who have ER/PR for primary breast cancer. But
 13 in October '05, at that point in time, we
 14 wouldn't be at this with that final number, it
 15 was an approximate number of 3000 patients who
 16 had an ER/PR test performed.
 17 CROSBIE, Q.C.:
 18 Q. All right.
 19 THE COMMISSIONER:
 20 Q. For whatever reason.
 21 MR. GULLIVER:
 22 A. For whatever reason, yes.
 23 CROSBIE, Q.C.:
 24 Q. And do I get that there may be another hundred
 25 who had the test for tumours of unknown

Page 302

1 primary origin?
 2 MR. GULLIVER:
 3 A. Could be more than that, a bit more than that,
 4 yes.
 5 CROSBIE, Q.C.:
 6 Q. How many?
 7 MR. GULLIVER:
 8 A. I can't tell you an exact number, but I mean,
 9 it's somewhere between this number and 3000.
 10 It could be 150, it could be 175.
 11 CROSBIE, Q.C.:
 12 Q. Okay. And do you know what the current
 13 estimate of the number of patients tested
 14 false positive is now?
 15 MR. GULLIVER:
 16 A. No, I don't.
 17 CROSBIE, Q.C.:
 18 Q. That we get from NLCHI, does 386 mean anything
 19 to you?
 20 MR. GULLIVER:
 21 A. No.
 22 CROSBIE, Q.C.:
 23 Q. It doesn't. So from your experience, though,
 24 you told Ms. Chaytor that you thought that
 25 certainly ten percent or less of the patients

Page 303

1 who were tested during this period were
 2 affected, that's how you put it.
 3 MR. GULLIVER:
 4 A. That would be affected by this whole retest
 5 process.
 6 CROSBIE, Q.C.:
 7 Q. Uh-hm. Yet the patient group who stood to be
 8 most affected would be the ones who tested
 9 negative during the period, wouldn't they?
 10 MR. GULLIVER:
 11 A. They would be, yes.
 12 CROSBIE, Q.C.:
 13 Q. There's something I don't understand here, so
 14 I'm going to ask you to try and enlighten me.
 15 I'm not sure if I picked up that there are
 16 patients you discovered going through your--
 17 through Meditech and through the pathology
 18 reports, there were patients for whom ER/PR
 19 had not been requisitioned, do I understand
 20 that to be the case?
 21 MR. GULLIVER:
 22 A. They were not ordered in the Meditech system,
 23 yes.
 24 CROSBIE, Q.C.:
 25 Q. They were not ordered.

Page 304

1 MR. GULLIVER:
 2 A. Yeah.
 3 CROSBIE, Q.C.:
 4 Q. And therefore not done?
 5 MR. GULLIVER:
 6 A. Oh they were done. So what would happen, Mr.
 7 Crosbie, the pathologists who were in the
 8 reporting room most of times doing their
 9 readings, they would fill out a manual IHC
 10 requisition form and then that form would go
 11 to the technologist to perform the testing,
 12 but then the technologist would do the data
 13 entry and put their request in the computer
 14 system on behalf of the pathologist to say Dr.
 15 So and So wants an ER/PR on this patient. And
 16 they would go and physically order the test in
 17 the computer system and then when the slides
 18 were completed, they would go back and say and
 19 they're now complete and done and bring them
 20 back. We came across, you know, there were a
 21 handful of situations where that function was
 22 not completed by the technologist and again,
 23 over the almost 3000 total ER/PR tests done, I
 24 think we came across eight or nine or ten
 25 cases where the paper requisition wasn't

Page 305

1 transcribed into the computer record.
 2 CROSBIE, Q.C.:
 3 Q. Uh-hm. But you could discover a result
 4 because the testing was done.
 5 MR. GULLIVER:
 6 A. The testing was done and the pathologist had
 7 put the result into the computer system--in
 8 the patient's report.
 9 CROSBIE, Q.C.:
 10 Q. So there was a result there to be looked at?
 11 MR. GULLIVER:
 12 A. Yes.
 13 CROSBIE, Q.C.:
 14 Q. Okay, so that actually didn't result in any
 15 distortion of anything, it was just a matter
 16 of maybe, well it's just a matter of finding
 17 out what the result as entered by the
 18 pathologist was?
 19 MR. GULLIVER:
 20 A. Right.
 21 CROSBIE, Q.C.:
 22 Q. Then was there a category of patients for whom
 23 ER/PR was requisitioned but there was no test
 24 or no report and--or have I got that wrong.
 25 Is that the same thing you just described to

Page 306

1 me?
 2 MR. GULLIVER:
 3 A. No, and there were, I think there might have
 4 been two or three cases in total, Mr. Crosbie,
 5 where in reading all the reports, we came
 6 across where there was an ER/PR ordered in the
 7 system, but in reading through the whole
 8 pathologist report, there was no indication of
 9 a result on the patient's report.
 10 CROSBIE, Q.C.:
 11 Q. It either hadn't been done or it hadn't been
 12 reported?
 13 MR. GULLIVER:
 14 A. One or the other.
 15 CROSBIE, Q.C.:
 16 Q. Yeah, and that's maybe two or three?
 17 MR. GULLIVER:
 18 A. I think there's only two or three cases, yes.
 19 CROSBIE, Q.C.:
 20 Q. And so what was done with those? You went and
 21 sent those to Mount Sinai, I guess.
 22 MR. GULLIVER:
 23 A. And they were gone back, checked and reviewed
 24 and then if they had to be retested, were
 25 retested, yes.

Page 307

1 CROSBIE, Q.C.:
 2 Q. Well it wouldn't be a retest because you
 3 couldn't figure out if it had been tested
 4 already.
 5 MR. GULLIVER:
 6 A. I think when we went through them, there were
 7 original slides, but there was no result
 8 documented into the computer system.
 9 CROSBIE, Q.C.:
 10 Q. So did someone read the slide before the block
 11 or whatever was sent to Mount Sinai?
 12 MR. GULLIVER:
 13 A. I don't know what Dr. Cook or Dr. Fontaine did
 14 with the -
 15 CROSBIE, Q.C.:
 16 Q. Yeah, this may be a small effect, but I'm
 17 guessing that the two or three people for whom
 18 no result could be found, either not reported
 19 or because the test was not done, well they
 20 can't show up in the false negative rate
 21 because there's no -
 22 MR. GULLIVER:
 23 A. I know and that was so small that really it's
 24 not going to change significantly anything on
 25 these spreadsheets here.

Page 308

1 CROSBIE, Q.C.:
 2 Q. However, I suppose they could have been
 3 deprived of an opportunity for a therapy that
 4 otherwise might have been offered to them.
 5 MR. GULLIVER:
 6 A. And again, I mean that's certainly a
 7 possibility, yes.
 8 CROSBIE, Q.C.:
 9 Q. One might want to ask--this is outside your
 10 scope, I suppose, one might want to ask the
 11 oncologist how it didn't get noticed. Dr.
 12 Ejeckam, when we looked--I don't know if you
 13 saw this, it's still up here--no it's not
 14 still up there.
 15 MR. GULLIVER:
 16 A. I think you had something, you had a statistic
 17 when, after Dr. Ejeckam's intervention in
 18 2003.
 19 CROSBIE, Q.C.:
 20 Q. Yeah, Dr. Ejeckam's table there. Just
 21 briefly, just for the sake do you have any
 22 idea about this, Dr. Ejeckam seemed to have
 23 improved the positivity rate in the wake of
 24 his interjection or his intervention, but not
 25 the false negative rate. I'm just wondering

Page 309

1 if you had any suggestion as to why that would
 2 be?
 3 MR. GULLIVER:
 4 A. It really--I really can't comment on that.
 5 CROSBIE, Q.C.:
 6 Q. Okay. Now if I could ask you about standard
 7 operating procedure manuals, you know who I
 8 mean by Dr. Dabbs?
 9 MR. GULLIVER:
 10 A. I know he was here, I didn't hear his
 11 testimony but I know he was here.
 12 CROSBIE, Q.C.:
 13 Q. Eminent authority in lab medicine, pathology,
 14 IHC testing and so forth. Anyway, you've
 15 heard of him, right?
 16 MR. GULLIVER:
 17 A. I've heard of him, yes.
 18 CROSBIE, Q.C.:
 19 Q. And you know he testified here.
 20 MR. GULLIVER:
 21 A. Yes.
 22 CROSBIE, Q.C.:
 23 Q. So, sir, when you were lab manager, there was
 24 no SOP in the sense that the witnesses we've
 25 heard here have described it, there's no SOP

Page 310

1 for ER/PR testing, was there?
 2 MR. GULLIVER:
 3 A. Well, you've seen what we submitted is that we
 4 had a procedure and multiple procedures, but
 5 they certainly were not to the level of what
 6 Trish would have expected to see and that's
 7 well documented now.
 8 CROSBIE, Q.C.:
 9 Q. They were manufacturer specs and procedures
 10 marked up by you in your handwriting, and
 11 maybe others?
 12 MR. GULLIVER:
 13 A. Well they were marked up by me after the fact
 14 in submitting them to the Inquiry.
 15 CROSBIE, Q.C.:
 16 Q. Okay. So you didn't see a need for an SOP?
 17 MR. GULLIVER:
 18 A. No, I've never said that.
 19 CROSBIE, Q.C.:
 20 Q. You didn't have one.
 21 MR. GULLIVER:
 22 A. Well we did have an operating procedure and
 23 protocols, we didn't have them in a format and
 24 a template as I've testified that Trish would
 25 expect in Mount Sinai, that one would expect

Page 311

1 if you were going through an accreditation
 2 process like the QMPLS process in Ontario and
 3 we didn't have them in formats like the
 4 Clinical Lab Standard Institute from the
 5 United States, as what Trish had recommended.
 6 And when you're able to have those in those
 7 templates, you know, you're able to have them
 8 signed off by the signing authorities, you
 9 have to put a date there when they must be
 10 reviewed over a certain period of time -
 11 CROSBIE, Q.C.:
 12 Q. This is what we've heard.
 13 MR. GULLIVER:
 14 A. And those are things that we did not do. I
 15 mean, that's well--we've acknowledged that.
 16 CROSBIE, Q.C.:
 17 Q. At the time you thought what you had was
 18 enough?
 19 MR. GULLIVER:
 20 A. At the time I thought what we had was enough
 21 for the staff to perform the procedure
 22 correctly. We were following the protocols
 23 and again, we relied heavily upon the
 24 pathologists' feedback and their
 25 interpretation.

Page 312

1 CROSBIE, Q.C.:
 2 Q. Dr. Dabbs told the Inquiry that the absence of
 3 an SOP in the sense we're talking about, is a
 4 recipe for disaster. In retrospect, do you
 5 agree?
 6 MR. GULLIVER:
 7 A. I think in retrospect there's a lot of things
 8 we had absent.
 9 CROSBIE, Q.C.:
 10 Q. That you rather you'd have.
 11 MR. GULLIVER:
 12 A. Yes.
 13 CROSBIE, Q.C.:
 14 Q. That might have made for a better quality
 15 test.
 16 MR. GULLIVER:
 17 A. I think that would have made for minimizing
 18 the risk or chance of reducing our false
 19 negatives because you're going to have false
 20 negatives. We obviously had more false
 21 negatives than you would see in most other
 22 major teaching labs.
 23 CROSBIE, Q.C.:
 24 Q. And NLCHI will tell us exactly how many that
 25 was. Madam Registrar, could I ask you to go

Page 313

1 to Dr. Cook's transcript again, page 232?
 2 Here, Dr. Cook is being asked by Mr. Coffey,
 3 it's between pages 232 and 236, about cost
 4 benefit analysis. Because we remember that
 5 you and Dr. Cook signed, as co-authors, a
 6 proposal in October, 2005 and you were taken
 7 through that in the last few days.
 8 MR. GULLIVER:
 9 A. Yes.
 10 CROSBIE, Q.C.:
 11 Q. Which came up with a budget and you defined a
 12 goal and the goal was to provide an equivalent
 13 ER/PR and immunohistochemical testing service,
 14 equivalent to that of the reference lab in
 15 Mount Sinai, that was your goal?
 16 MR. GULLIVER:
 17 A. And that submission was more to do with the
 18 resources required to work towards that goal.
 19 CROSBIE, Q.C.:
 20 Q. Right. There's a budget in there too,
 21 \$282,000 is what you estimated at the time and
 22 I think you said it's actually turned out to
 23 cost more.
 24 MR. GULLIVER:
 25 A. I think we spent more than that, yes.

Page 314

1 CROSBIE, Q.C.:
 2 Q. So your initial thought that reallocating
 3 \$20,000 or thereabouts from the biochemical
 4 laboratory in 1997, that turned out not to be
 5 a correct assumption.
 6 MR. GULLIVER:
 7 A. At the time it was the right assumption,
 8 that's how much money was required to start
 9 performing the ER/PR procedure in that IHC lab
 10 under the guidance of Dr. Khalifa.
 11 CROSBIE, Q.C.:
 12 Q. To what standard?
 13 MR. GULLIVER:
 14 A. Well what you see in 2005 is really a report
 15 that addresses the pathology laboratory
 16 overall, where a new resources where we now
 17 have approval to create pathologist
 18 assistants, i.e. we take technologists and
 19 train them up to do the grossing, that was a
 20 large chunk of the new resources required for
 21 that report. We also asked for, I think a
 22 fulltime med lab assistant and those things
 23 were to address other parts of the pathology
 24 lab. We asked for dedicated funding for
 25 education for the staff in IHC for pathology.

Page 315

1 But at the time, Mr. Crosbie, '97, you know,
 2 we looked at what resources were required to
 3 actually perform the testing. There was no
 4 thought given to well let's now, because we're
 5 doing ER/PR testing, let's now hire pathology
 6 assistants, let's now put in this or this. I
 7 mean, it wasn't thought of back then.
 8 CROSBIE, Q.C.:
 9 Q. Well with the luxury of hindsight, it might
 10 seem to some people that the question should
 11 have been asked what resources, human and
 12 financial, were going to be required to do
 13 this testing service in the new manner, moving
 14 it from biochemistry over to histology, to an
 15 acceptable standard. And if the answer was
 16 that the authorities in the organization were
 17 not prepared to fund those resources, then it
 18 shouldn't have been done.
 19 MR. GULLIVER:
 20 A. Well I'm saying to you what was done, the
 21 authorities in the organization were not asked
 22 for additional resources. Dr. Khalifa worked
 23 with Dr. Prabhakaran in biochemistry. It was
 24 moving a testing methodology from biochemistry
 25 to pathology to another part of the

Page 316

1 laboratory, and we already had two
 2 technologists who were skilled in doing IHC
 3 testing. The biggest obstacle would have been
 4 having a pathologist with the expertise to
 5 interpret the testing. And we had that, we
 6 now had that pathologist on site in St.
 7 John's, Dr. Khalifa and the resources required
 8 was the actual operation's money to order the
 9 supplies and reagents in order to add that to
 10 the existing pool of antibodies that was
 11 taking place in the pathology lab.
 12 CROSBIE, Q.C.:
 13 Q. So a lot of the difference, by the time you
 14 got to 2005, October, and signed that joint
 15 proposal with a budget with Dr. Cook, is that
 16 you knew a lot more about what was required to
 17 do this right, than you did in 1997?
 18 MR. GULLIVER:
 19 A. I think we realized in 2005 that a large
 20 segment of an issue, as we've talked about the
 21 possibility of specimens being not fixed
 22 properly or grossed properly and if the
 23 thickness of the tissue submitted is not
 24 proper, that by 2005, we're at a position
 25 where we realize we need to have a dedicated

1 core team of people to do all the surgical
 2 grossing, and that would require the
 3 additional hire of four new staff and training
 4 of those four staff. I mean, what else we've
 5 learned since 2005 is obviously we
 6 wholeheartedly agree with all the
 7 recommendations from Ms. Wegrynowski and from
 8 Dr. Banerjee, you know, is the documentation
 9 of all the work processes in pathology,
 10 including technical and clinical. We've also
 11 learned that we started this test with Dr.
 12 Khalifa, who in my opinion was an expert in
 13 breast pathology in this field, and we now
 14 have gone back to that process where we have a
 15 dedicated team of pathologists ensuring that
 16 they are reading all of those slides.

17 CROSBIE, Q.C.:

18 Q. There is no defined objective back in 1997,
 19 was there, nothing set down in writing?

20 MR. GULLIVER:

21 A. To my knowledge, I don't remember Dr. Khalifa
 22 doing anything in writing as an objective. I
 23 just think it was something that he worked
 24 with, the biochemistry staff and our clinical
 25 chief at the time and the program director and

1 MR. GULLIVER:

2 A. Well, the budget piece was done, that I had
 3 submitted an official request to Mr. Whelan to
 4 say that in our estimation it will cost
 5 \$20,000.00 additional to perform this testing

1 came forward and said that there was a new way
 2 to do this test, it would mean that there
 3 would be a permanent record kept, where it was
 4 done in pathology on a paraffin block and a
 5 glass slide. It also meant the patients
 6 didn't have to go through a lumpectomy to get
 7 a sample for chemistry, it could be done using
 8 a biopsy, so it was much more less
 9 intervention.

10 CROSBIE, Q.C.:

11 Q. And I think we understand the reasons why this
 12 was considered to be a good shift, but what
 13 I'm saying is there is no defined objective,
 14 in terms of quality or standard for this
 15 testing to meet, no institution was
 16 referenced, like Mount Sinai and there is no
 17 budget drawn up for the resources needed to
 18 achieve that objective. And I think the
 19 answer to that is quite obviously, yes, there
 20 was no such thing.

1 in pathology, and my recommendation would -
 2 was that resources that were currently used in
 3 chemistry to perform the test, to switch those
 4 resources to the pathology budget. The other
 5 piece of it, Mr. Crosbie, to my knowledge, was
 6 not done, but I think that Dr. Khalifa should
 7 be asked that question.

8 CROSBIE, Q.C.:

9 Q. Indeed, and the \$20,000.00 was estimated and
 10 sought at the time when your understanding of
 11 the test was much more in its beginning stages
 12 than it became?

13 MR. GULLIVER:

14 A. No, at that time I knew how much it was going
 15 to cost because Dr. Khalifa - we had gotten
 16 the cost from DAKO to purchase reagents and
 17 Dr. Khalifa had given an estimate of how many
 18 patients we expect to do a year, and we
 19 estimated it was going to cost on average
 20 about \$100.00 per patient, and he figured it
 21 would be about 200 cases done a year, times
 22 100 was \$20,000.00.

23 CROSBIE, Q.C.:

24 Q. Could we bring up Dr. Cook, page 303 to 304.

25 REGISTRAR:

Page 320

1 Q. I think you're looking for July 7th.
 2 CROSBIE, Q.C.:
 3 Q. Yeah, it's not the right date. Thank you, by
 4 the way for straightening this out. I think
 5 the Registrar was concerned it was about to
 6 topple over.
 7 THE COMMISSIONER:
 8 Q. We're very conscious of quality control, Mr.
 9 Crosbie.
 10 CROSBIE, Q.C.:
 11 Q. And health and life safety. So is this what
 12 we're looking for? Okay, so right about line
 13 11, page 303 and then just over to 304.
 14 MR. GULLIVER:
 15 A. Start reading page 303?
 16 CROSBIE, Q.C.:
 17 Q. Yes. You see there that Dr. Cook is saying
 18 that we were in reality nothing more than a
 19 glorified community lab. As a lab man, could
 20 we have your comment on that?
 21 MR. GULLIVER:
 22 A. Well, I think Dr. Cook is actually stating
 23 that, I think, in retrospect, and I think Dr.
 24 Cook is probably talking about, in particular,
 25 the pathology department. I don't think that

Page 321

1 he's talking about the lab medicine program.
 2 I think he's talking about pathology, in
 3 particular, and I guess by the time Don gives
 4 his testimony this summer, you know, we've
 5 seen that as a university teaching hospital,
 6 when it came to our pathology department, and
 7 you look at our practises - for example,
 8 pathologist assistants, you know, most major
 9 tertiary care hospitals, teaching hospitals in
 10 the country, had long ago had pathologist
 11 assistants that would assist the pathologists
 12 and do - standardize the fixation, grossing,
 13 and those practices. Most university teaching
 14 hospitals in this country would have had
 15 dedicated technologists and managers that
 16 oversaw quality management for laboratory
 17 services.
 18 CROSBIE, Q.C.:
 19 Q. These things were missing back in the period?
 20 MR. GULLIVER:
 21 A. Well, they're missing up until just recently,
 22 and I think that's - what Dr. Cook is
 23 referring to, I certainly - when you look at
 24 other parts of our laboratory medicine
 25 program, I think, you know, our biochemistry

Page 322

1 division and other divisions may take
 2 exception to that assessment that they're a
 3 community lab and not a university teaching
 4 lab.
 5 CROSBIE, Q.C.:
 6 Q. Sir, let me put something to you. In ER/PR
 7 testing, the lab could have performed to the
 8 standard of Mount Sinai if the service had
 9 been established on sound principles and
 10 adequately resourced from the start. Do you
 11 agree?
 12 MR. GULLIVER:
 13 A. I think from the start it was sound principles
 14 because I think that we had the luxury of
 15 having Dr. Khalifa here to put that testing in
 16 place, we had the luxury of him reviewing the
 17 control slides, and we had the luxury of him
 18 pretty well doing almost all the
 19 interpretations, and we had the resources at
 20 the time to perform the testing. We didn't
 21 have the resources at the time to have a level
 22 of documentation of what we see today.
 23 CROSBIE, Q.C.:
 24 Q. That's your comment?
 25 MR. GULLIVER:

Page 323

1 A. I think that's - well, you've asked for my
 2 opinion and that's how I feel.
 3 CROSBIE, Q.C.:
 4 Q. If the service could not be established with
 5 adequate resources, it should have been
 6 referred out.
 7 MR. GULLIVER:
 8 A. And I submit to you that when the service was
 9 started with Dr. Khalifa, we had adequate
 10 resources to perform the testing and do the
 11 interpretations.
 12 CROSBIE, Q.C.:
 13 Q. Including the human resources in the form of
 14 expertise on the bench?
 15 MR. GULLIVER:
 16 A. Well, the two technologists had been - had ten
 17 years experience in IHC testing, and you've
 18 heard Dr. Khalifa who came in from Sunnybrook
 19 and testified. He said when he first came to
 20 St. John's and he had come from Washington,
 21 DC, and other large centres, he said that he
 22 was impressed with the level and quality of
 23 service from the technologists in the IHC lab.
 24 CROSBIE, Q.C.:
 25 Q. And he must have been of the view that your

Page 324

1 staff in the lab adequately understood the
 2 delicacy of the test?
 3 MR. GULLIVER:
 4 A. Again you'll have to ask Dr. Khalifa that.
 5 CROSBIE, Q.C.:
 6 Q. Lastly, Rosalind Jardine testified here in
 7 April. She was one of the patients who
 8 testified initially. I spoke to her myself
 9 last week, I met with her, and she continues
 10 well, you may be pleased to know,
 11 Commissioner, although she - and she knew at
 12 that time that she'd had a recurrence. She's
 13 in her 50s, and she believes that she should
 14 have been on Tamoxifen several years before it
 15 was offered. In relation to ER/PR testing
 16 problems, what if any personal responsibility
 17 do you take for that?
 18 MR. SIMMONS:
 19 Q. Commissioner, I don't think that's a fair
 20 question for Mr. Gulliver. It's not grounded
 21 in any particular evidence (inaudible). The
 22 analysis is just an open ended question. I
 23 don't think it's fair that now Mr. Gulliver
 24 has to respond to -
 25 CROSBIE, Q.C.:

Page 325

1 Q. I'm attempting to give the question of
 2 responsibility a human face, Commissioner, and
 3 that's somebody who testified here back six
 4 months ago. My suggestion is that the patient
 5 population whose lives are involved in this
 6 would like to hear from the responsible
 7 persons in Eastern Health whether and to what
 8 extent they accept responsibility for what
 9 these patients have had to endure.
 10 MR. SIMMONS:
 11 Q. Commissioner, there's been many witnesses from
 12 Eastern Health that Mr. Crosbie has had the
 13 opportunity to ask such questions to, if he
 14 wanted to depose them, the proper position
 15 would have been to depose them to someone like
 16 the CEO or people in authority to speak up now
 17 within the organization. He hasn't chosen to
 18 address other witnesses from Eastern Health in
 19 this way. And I don't think he should now be
 20 put in a position - Mr. Gulliver shouldn't be
 21 put in a position to have to take that kind of
 22 burden and responsibility upon himself to
 23 answer that question.
 24 THE COMMISSIONER:
 25 Q. Your question again was?

Page 326

1 CROSBIE, Q.C.:
 2 Q. My question is what, if any, personal
 3 responsibility do you take for the women who
 4 feel that they should have had therapy earlier
 5 than they have. He can answer or not.
 6 THE COMMISSIONER:
 7 Q. Are you saying he can answer or not? You're
 8 giving the witness an opportunity to answer
 9 the question if he wishes, is that the idea?
 10 CROSBIE, Q.C.:
 11 Q. Yes, I can hardly - I'm not going to beat him
 12 around the head if he doesn't want to answer
 13 that.
 14 MR. SIMMONS:
 15 Q. Well, Commissioner, even doing that is putting
 16 the weight on Mr. Gulliver to decide whether
 17 he feels the pressure to address a question
 18 like that. Personal responsibility is not
 19 within the mandate of really of what the
 20 Commission is all about. It's getting -
 21 THE COMMISSIONER:
 22 Q. It is true that I'm not to determine any
 23 personal liability in respect of any
 24 particular person, as Mr. Crosbie knows all
 25 too well. The question of liability is -

Page 327

1 CROSBIE, Q.C.:
 2 Q. Well, strike the word "personal".
 3 THE COMMISSIONER:
 4 Q. Is to be determined elsewhere, but what you
 5 are - if you are giving this witness an
 6 opportunity to comment on a personal level
 7 about the circumstances of the patients, then
 8 I'm prepared to let him comment if he wishes
 9 to do so. He does not have, however, to -
 10 he's not obliged to do so. So do you
 11 understand what's happened?
 12 MR. GULLIVER:
 13 A. I do, and I think my answer would be that my
 14 closing statement will probably answer that.
 15 THE COMMISSIONER:
 16 Q. Okay. So it appears, Mr. Crosbie, that there
 17 will be an answer. Mr. Simmons.
 18 MR. SIMMONS:
 19 Q. Thank you, Commissioner.
 20 THE COMMISSIONER:
 21 Q. Mr. Simmons, do you want that left as it is?
 22 Are you prepared to enter into this dangerous
 23 ground?
 24 MR. SIMMONS:
 25 Q. I think the quality assurance manager has

Page 328

1 addressed it satisfactorily. I won't be long,
 2 Commissioner. Mr. Gulliver, you'll be happy
 3 to know I won't be very long either.
 4 MR. TERRY GULLIVER - EXAMINATION BY MR. DAN SIMMONS
 5 MR. SIMMONS:
 6 Q. I just had actually one very specific thing to
 7 ask you about. I'd like to have Exhibit P-
 8 1373 again, please. This is one that Ms.
 9 Newbury showed you, and it's an e-mail message
 10 from Heather Predham to a number of people,
 11 not to you, on May 18th, 2006, and there was a
 12 table attached to it here. You'd said you
 13 weren't familiar with the particular message.
 14 In the text of it, Ms. Predham says that
 15 "Kara", and that would be Dr. Laing, the
 16 oncologist, "and I reviewed the retro list and
 17 here is the final list that will need to be
 18 reviewed", and attached to it there is a table
 19 which has, I think, eight separate lines there
 20 for separate entries. I'm going to ask you
 21 just to presume that the four that were
 22 ultimately identified as the retro converters
 23 are included on these listed here.
 24 MR. GULLIVER:
 25 A. I think they are, yes.

Page 329

1 MR. SIMMONS:
 2 Q. And you'll see that there's an original ER
 3 result, an original PR, a Mount Sinai ER, and
 4 a Mount Sinai PR, and if we look at the first
 5 entry across, the name and the specimen
 6 numbers and the RS numbers are all blocked
 7 out. I'm going to ask you to assume that the
 8 first line there has a specimen number for
 9 1999.
 10 MR. GULLIVER:
 11 A. I was just going to ask that question, what
 12 year are these from?
 13 MR. SIMMONS:
 14 Q. Assume the first one is from 1999. The
 15 original ER of 25 to 30, would that specimen
 16 have met the criteria for retesting of
 17 negatives?
 18 MR. GULLIVER:
 19 A. Yes.
 20 MR. SIMMONS:
 21 Q. Okay, and -
 22 MR. GULLIVER:
 23 A. Again I had testified that anything we seen
 24 close to even the 25 to 30, even, say, 25 to
 25 35, that those patients were all put on the

Page 330

1 spreadsheet to be reviewed for retesting.
 2 MR. SIMMONS:
 3 Q. Right, and the second entry there, assume as
 4 well that the second entry is from the period
 5 prior to the year 2000.
 6 MR. GULLIVER:
 7 A. So that would be retested, yes.
 8 MR. SIMMONS:
 9 Q. That one has an original ER of 30. So that
 10 would be considered a clinical negative and
 11 selected for retesting?
 12 MR. GULLIVER:
 13 A. Yes.
 14 MR. SIMMONS:
 15 Q. And the remaining entries there are either
 16 negative 10 or WP, and do you know what WP
 17 would indicate?
 18 MR. GULLIVER:
 19 A. Well, that means it would have said a weak
 20 positive would have been the interpretation in
 21 the patient's report.
 22 MR. SIMMONS:
 23 Q. So all of these entries here, would these all
 24 have met the criteria for selection for
 25 retesting at Mount Sinai?

Page 331

1 MR. GULLIVER:
 2 A. Yes.
 3 MR. SIMMONS:
 4 Q. And would any of them have been considered
 5 positives, which would have been excluded from
 6 the retesting?
 7 MR. GULLIVER:
 8 A. No, no.
 9 MR. SIMMONS:
 10 Q. Okay. So - and in these particular cases,
 11 these tests then were reported by Mount Sinai
 12 as having an ER and PR of zero or very low
 13 numbers?
 14 MR. GULLIVER:
 15 A. Uh-hm.
 16 MR. SIMMONS:
 17 Q. Now aside from any cases where there is no
 18 order entered for a test, can we safely say
 19 that all cases like these where the original
 20 ER fell within the testing criteria were
 21 selected for retesting and have been retested?
 22 MR. GULLIVER:
 23 A. Yes, every one.
 24 MR. SIMMONS:
 25 Q. So there would be no other similar cases that

Page 332

1 we're aware of that we could locate?

2 MR. GULLIVER:

3 A. No.

4 MR. SIMMONS:

5 Q. That need to be retested, okay. Now another

6 example here, if we look at the third line,

7 there's one there from Carbonear which had an

8 original ER negative and an original PR of 50

9 to 60, and that original PR, 50 to 60, would

10 be above the - if the cutoff were being

11 applied to it, that would be considered a

12 positive result, correct?

13 MR. GULLIVER:

14 A. For PR.

15 MR. SIMMONS:

16 Q. For PR.

17 MR. GULLIVER:

18 A. Yes.

19 MR. SIMMONS:

20 Q. And but since the ER is negative, then that

21 was -

22 MR. GULLIVER:

23 A. Was an automatic retest.

24 MR. SIMMONS:

25 Q. Selected for retesting.

Page 333

1 MR. GULLIVER:

2 A. Yeah.

3 MR. SIMMONS:

4 Q. Okay. So among all the tests that were

5 identified and reviewed for retesting, are

6 there any cases where there was a negative ER

7 and a PR that was 30 or higher which were

8 excluded from retesting?

9 MR. GULLIVER:

10 A. No, none.

11 MR. SIMMONS:

12 Q. No. So every case that falls into that

13 category has been retested, and if any of

14 those were to have changed to

15 negative/negative on retesting, we would be

16 aware of them?

17 MR. GULLIVER:

18 A. Yes.

19 MR. SIMMONS:

20 Q. Okay. Now Mr. Gulliver, I understand you do

21 have a statement that you would like to make.

22 MR. GULLIVER:

23 A. Finally, after all these days.

24 MR. SIMMONS:

25 Q. This is your opportunity.

Page 334

1 MR. GULLIVER:

2 A. Thank you. It's a short statement. Over

3 these past few days, and months, the

4 Commission has heard from various witnesses,

5 including myself, regarding the years of cost

6 cutting and downsizing that impacted

7 laboratory medicine. The laboratory, in my

8 opinion, has for years been viewed as a call

9 centre within the health care system, and in

10 difficult financial times, the laboratory was

11 required to reduce expenditures. This inquiry

12 has put the laboratory and the health care

13 system in general under the microscope. The

14 laboratory, I feel, is now viewed as a value

15 centre and not a call centre, as we are now

16 recognized for the critical role we play in

17 patient care. Eastern Health laboratories,

18 with its 500 staff, produce over 10 million

19 results every year that physicians and

20 patients rely upon for diagnosis, prognosis,

21 treatment, and preventive care. Even though

22 the laboratory and health care in general

23 underwent many years of downsizing and reduced

24 budgets, I feel that every technologist,

25 pathologist, manager, oncologist,

Page 335

1 administrator, came to work every day and did

2 their best to serve our patients. However, at

3 times our best was not good enough for some of

4 our patients, and when I say patients, that

5 includes my family, your families, co-workers

6 and my friends. The list of approximately

7 1000 patients that I helped organize for

8 retesting was not just a list of names. The

9 list included friends of mine and staff.

10 During this review process, I lost a very dear

11 friend of mine, she was 40 years old, due to

12 breast cancer. In the summer of 2005 when the

13 decision was made to review and retest all

14 patients that tested negative, I was in full

15 support because as a laboratory professional,

16 I felt a duty to do anything I possibly could

17 to help serve our patients. However, at that

18 time I never realized the full magnitude of

19 the issue and the enormous amount of time it

20 was going to take. Myself, my manager,

21 technologists, and pathologists were focused

22 on reviewing, identifying, and getting samples

23 organized for retesting. Now three years

24 later, after much anguish by many of the

25 patient and their families affected by the

1 retesting, and after thousands of additional
 2 hours of work by our laboratory staff and
 3 others, the work still continues. You have
 4 heard through this inquiry that much good as
 5 come from this. You have heard that our
 6 laboratory today has improved tissue fixation
 7 and tissue preparation.

8 MR. GULLIVER:
 9 A. You have heard that our laboratory has
 10 improved its testing and the documentation of
 11 the testing. You have heard that our
 12 laboratory has improved its reporting and
 13 interpretation of this testing and you have
 14 also heard that our oncologists have improved
 15 the clinical treatment based upon this
 16 testing.
 17 All of the above would not be possible
 18 without the support of Government, Eastern
 19 Health and the new resources that have been
 20 added to the laboratory and other parts of the
 21 health care system, and this support must
 22 continue.
 23 We, in the laboratory, and all parts of

1 other questions, Commissioner.
 2 THE COMMISSIONER:
 3 Q. Do you have anything arising, Ms. Chaytor?
 4 MR. TERRY GULLIVER, EXAMINATION BY SANDRA CHAYTOR, Q.C.
 5 CHAYTOR, Q.C.:
 6 Q. Just one. I don't know if you can see me or
 7 not, but hopefully you can hear me. This
 8 arose out of a question, Mr. Gulliver, that
 9 Mr. Crosbie asked you, and Registrar, if we
 10 could have, please, P-1852? In asking about
 11 the standard operating procedures at the time,
 12 I think it's at page nine of this exhibit, and
 13 you were brought to this exhibit which was
 14 filed as part of the appendix to the answers
 15 to interrogatories at the time, and I believe
 16 you are indicating that this would be the
 17 standard operating procedures that the staff,
 18 the technologists, would have been using in
 19 performing the ER/PR tests throughout the
 20 period that the DAKO machine was used?
 21 MR. GULLIVER:
 22 A. Yes.
 23 CHAYTOR, Q.C.:
 24 Q. Okay, and I understood you to say to Mr.
 25 Crosbie that you did have a procedure and this

1 the health care system that are involved in
 2 breast cancer testing and treatment, have
 3 gained a huge amount of knowledge through this
 4 whole process. When I started my testimony
 5 here, it was Canadian Patient Safety Week and
 6 this year's theme is knowledge is the best
 7 medicine. My hope and my vision is that the
 8 knowledge gained through the past three years,
 9 and in particular, the knowledge gained from
 10 this Commission of Inquiry, is truly used to
 11 ensure that Eastern Health's laboratory will
 12 be recognized as a leader within Canada. I
 13 hope that our laboratory will be given the
 14 resources to do so and I feel that we have
 15 dedicated and qualified technologists and
 16 pathologists and support staff to help us
 17 achieve that goal.
 18 In closing, I would like to thank you,
 19 Madam Justice Cameron and her counsel for the
 20 opportunity to speak at this Inquiry and more
 21 importantly, for the very professional manner
 22 in which you have treated all laboratory staff
 23 who have been called to testify. Thank you.

24 MR. SIMMONS:
 25 Q. Thank you, Mr. Gulliver. I don't have any

1 is your procedure, but not to the level -
 2 MR. GULLIVER:
 3 A. This is the antibody specification sheet
 4 you're showing here.
 5 CHAYTOR, Q.C.:
 6 Q. Yes, on this page. I think page six,
 7 Registrar, it begins? Unfortunately, my
 8 mouse--oh, here it is, okay. Maybe it's page--
 9 here we go. Well, we saw it in one of the
 10 exhibits.
 11 MR. GULLIVER:
 12 A. Yes.
 13 CHAYTOR, Q.C.:
 14 Q. It was the -
 15 MR. GULLIVER:
 16 A. The actual step-by-step procedure.
 17 CHAYTOR, Q.C.:
 18 Q. Yes, the step by step, and then it was the
 19 specification sheet, and I just understood you
 20 to say that you had a procedure in place,
 21 while it might not have been to the standard
 22 that Trish Wegrynowski would have expected,
 23 that you did have a procedure in place, and I
 24 think you said it may not have been to the
 25 level she expected or the format that she was

Page 340

1 expecting?
 2 MR. GULLIVER:
 3 A. That's correct.
 4 CHAYTOR, Q.C.:
 5 Q. And my question is, Mr. Gulliver, are you
 6 telling the Commissioner that there was a
 7 standardized and consistent procedure in place
 8 for the testing of ER/PR throughout the entire
 9 time period that was followed by the
 10 technologists consistently, rigidly throughout
 11 the entire period?
 12 MR. GULLIVER:
 13 A. Yes, and that's my firm belief.
 14 CHAYTOR, Q.C.:
 15 Q. And do you know whether or not all of the
 16 technologists utilized the same antibody
 17 dilution?
 18 MR. GULLIVER:
 19 A. That I can't verify, I mean -
 20 CHAYTOR, Q.C.:
 21 Q. Wouldn't that be part of your standard
 22 operating procedure?
 23 MR. GULLIVER:
 24 A. That would be part of the protocol.
 25 CHAYTOR, Q.C.:

Page 341

1 Q. Yes.
 2 MR. GULLIVER:
 3 A. And the validation process of what antibody
 4 dilution to use, and I would be aware that at
 5 different times, you could use different
 6 antibody dilutions if the lot number changed
 7 or those kinds of things, and that's
 8 something, as you're well aware, you do during
 9 the validation or revalidation.
 10 CHAYTOR, Q.C.:
 11 Q. But would you expect that the--whichever
 12 technologist was doing the procedure would use
 13 the same dilution of antibody?
 14 MR. GULLIVER:
 15 A. Oh, I'm sorry, so if the recommended dilution
 16 was, say, one of 50?
 17 CHAYTOR, Q.C.:
 18 Q. Yes, that whether it's Peggy Welsh doing the
 19 test or Mary Butler doing the test -
 20 MR. GULLIVER:
 21 A. Irregardless, it would be done one of 50 every
 22 time.
 23 CHAYTOR, Q.C.:
 24 Q. Right. Do you know whether or not that was
 25 the case, that your technologists were all

Page 342

1 using the same antibody dilution at whatever
 2 that was for any particular time period?
 3 MR. GULLIVER:
 4 A. I can't guarantee you 100 percent, but to the
 5 best of my knowledge, the answer would be yes.
 6 CHAYTOR, Q.C.:
 7 Q. Do you know whether or not they were all
 8 utilizing the same incubation periods?
 9 MR. GULLIVER:
 10 A. To the best of my knowledge, yes.
 11 CHAYTOR, Q.C.:
 12 Q. Okay, and if they were to have told the
 13 Commissioner otherwise, you'd be unaware of
 14 that? If Mary was using -
 15 MR. GULLIVER:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. - a different dilution at a particular period
 19 in time than -
 20 MR. GULLIVER:
 21 A. And I'd be unaware and surprised.
 22 CHAYTOR, Q.C.:
 23 Q. You'd be surprised. And are you aware of any
 24 documentation--for example, this is written
 25 here, July 14th, 2003, one out of 20. Are you

Page 343

1 aware of, if we pick another date, we could
 2 say July 2nd 2002, which I believe is the date
 3 that Peggy Deane's test was carried out, is
 4 there any documentation that would tell us
 5 what your standard operating procedure was on
 6 that date?
 7 MR. GULLIVER:
 8 A. Well, it would be the same procedure as what
 9 we submitted to you.
 10 CHAYTOR, Q.C.:
 11 Q. And what would the dilution of the antibody be
 12 -
 13 MR. GULLIVER:
 14 A. I can't tell you what the dilution would be.
 15 CHAYTOR, Q.C.:
 16 Q. - or what the incubation period that the
 17 technologists were using?
 18 MR. GULLIVER:
 19 A. But generally, the technologists would write
 20 the dilution on the sheets and on the actual
 21 bottle that they were using.
 22 CHAYTOR, Q.C.:
 23 Q. And what about the incubation period?
 24 MR. GULLIVER:
 25 A. And that's set out in the procedure.

Page 344

1 CHAYTOR, Q.C.:

2 Q. Well, it gives an optimal period in the

3 procedure, in the spec sheet. Is that what

4 you're referring to?

5 MR. GULLIVER:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. But whether or not -

9 MR. GULLIVER:

10 A. I think they always used 30 minutes, but I

11 can't be 100 percent sure.

12 CHAYTOR, Q.C.:

13 Q. Thank you, that's it, Commissioner.

14 THE COMMISSIONER:

15 Q. Thank you. Thank you, Mr. Gulliver. I'm sure

16 it's been a long few days.

17 MR. GULLIVER:

18 A. It has, yes.

19 THE COMMISSIONER:

20 Q. Spread out over weeks. I do appreciate your

21 contribution. Thank you very much.

22 MR. GULLIVER:

23 A. Thank you so much.

24 THE COMMISSIONER:

25 Q. Ms. Chaytor, it's late in the day, but is the

Page 345

1 next witness here?

2 CHAYTOR, Q.C.:

3 Q. I believe she is.

4 THE COMMISSIONER:

5 Q. Let's--my suggestion is that we carry on until

6 five and let's get over the introduction and

7 let her get sworn in and have the--we'll

8 return that to the comfort level for Ms.

9 Chaytor. Thank you very much, gentlemen.

10 CHAYTOR, Q.C.:

11 Q. Thank you.

12 THE COMMISSIONER:

13 Q. Now Ms. Chaytor.

14 CHAYTOR, Q.C.:

15 Q. Commissioner, the next witness is Heather

16 Predham.

17 MS. HEATHER PREDHAM, SWORN, EXAMINATION BY SANDRA

18 CHAYTOR, Q.C.

19 REGISTRAR:

20 Q. Would you please state and spell your complete

21 name for the Commission?

22 MS. PREDHAM:

23 A. Heather Predham, H-E-A-T-H-E-R P-R-E-D-H-A-M.

24 REGISTRAR:

25 Q. Thank you.

Page 346

1 CHAYTOR, Q.C.:

2 Q. Good afternoon, Ms. Predham.

3 MS. PREDHAM:

4 A. Good afternoon.

5 CHAYTOR, Q.C.:

6 Q. And thank you for your patience.

7 MS. PREDHAM:

8 A. No problem.

9 CHAYTOR, Q.C.:

10 Q. We have a number of new exhibits that I would

11 ask, please, to have entered this afternoon,

12 Commissioner, and it's actually quite a

13 number, so that might eat up all of our time.

14 I hope not. Okay, so we have P-2939 through

15 to P-2944 inclusive, P-2948, P-2949, P- 2951

16 through to P-2957 inclusive, P-2960, P- 2965

17 through to P-2973 inclusive, P-2979 through to

18 P-2981 inclusive, P-2983 through to P- 3003

19 inclusive, P-3005 through to P-3029 inclusive,

20 P-3031 through to P-3035 inclusive, P-3037, P-

21 3040, P-3041, P-3043 through to P- 3048

22 inclusive, P-3049--no, I'm sorry, not P-3049.

23 P-3052 through to P-3054 inclusive, P-3056, P-

24 3059 through to P-3073 inclusive, P-3075, P-

25 3078, P-3370 through to P-3380 inclusive, P-

Page 347

1 3382 through P-3385 inclusive, P-3387 through

2 to P-3410, P-3413 through P-3415 inclusive, P-

3 3417, P-3418, P-3420 through to P-3462

4 inclusive and then we have four C exhibits, C-

5 0264, C-0265, C-0273 and C-0274. Is that it,

6 Registrar?

7 REGISTRAR:

8 Q. Yes.

9 CHAYTOR, Q.C.:

10 Q. Thank you.

11 THE COMMISSIONER:

12 Q. Entered.

13 EXHIBITS ENTERED AND MARKED P-2939 THROUGH P- 2944

14 EXHIBITS ENTERED AND MARKED P-2948 AND P-2949

15 EXHIBITS ENTERED AND MARKED P-2951 THROUGH P- 2957

16 EXHIBIT ENTERED AND MARKED P-2960

17 EXHIBITS ENTERED AND MARKED P-2965 THROUGH P- 2973

18 EXHIBITS ENTERED AND MARKED P-2979 THROUGH P- 2981

19 EXHIBITS ENTERED AND MARKED P-2983 THROUGH P- 3003

20 EXHIBITS ENTERED AND MARKED P-3005 THROUGH P- 3029

21 EXHIBITS ENTERED AND MARKED P-3031 THROUGH P- 3035

22 EXHIBIT ENTERED AND MARKED P-3037

23 EXHIBITS ENTERED AND MARKED P-3040 AND P-3041

24 EXHIBITS ENTERED AND MARKED P-3043 THROUGH P- 3048

25 EXHIBITS ENTERED AND MARKED P-3052 THROUGH P- 3054

1 EXHIBIT ENTERED AND MARKED P-3056
 2 EXHIBITS ENTERED AND MARKED P-3059 THROUGH P-3073
 3 EXHIBIT ENTERED AND MARKED P-3075
 4 EXHIBIT ENTERED AND MARKED P-3078
 5 EXHIBITS ENTERED AND MARKED P-3370 THROUGH P-3380
 6 EXHIBITS ENTERED AND MARKED P-3382 THROUGH P-3385
 7 EXHIBITS ENTERED AND MARKED P-3387 THROUGH P-3410
 8 EXHIBITS ENTERED AND MARKED P-3413 THROUGH P-3415
 9 EXHIBITS ENTERED AND MARKED P-3417 THROUGH P-3418
 10 EXHIBITS ENTERED AND MARKED P-3420 THROUGH P-3462
 11 EXHIBITS ENTERED AND MARKED C-0264 AND C-0265
 12 EXHIBITS ENTERED AND MARKED C-0273 AND C-0274
 13 CHAYTOR, Q.C.:
 14 Q. Thank you, Commissioner. Ms. Predham, perhaps
 15 you can begin by telling us about yourself,
 16 your educational and professional background.
 17 MS. PREDHAM:
 18 A. I graduated from Memorial University in 1986
 19 with a Bachelor of Nursing. I then was
 20 employed as a psychiatric nurse at the
 21 Waterford Hospital until--as a front-line
 22 psychiatric nurse until 1993. At that time, I
 23 worked with the medical department in quality,
 24 in that area, until 1994, and then I had the
 25 position as quality care coordinator at the

1 point? Did you get to know Mr. Dawe?
 2 MS. PREDHAM:
 3 A. Yes, for a period of time he was a social
 4 service worker, I believe, and he worked on
 5 the unit that I worked on at that time.
 6 CHAYTOR, Q.C.:
 7 Q. Okay, and then while you're still at the
 8 Waterford, from 1993 to 1994, what was your
 9 position at that period?
 10 MS. PREDHAM:
 11 A. In 1993, I was a medical resource person and
 12 that's a title they--I was almost an
 13 administrative support person with the
 14 physicians. I helped develop audits,
 15 developed policies, write their policy and
 16 procedure manual, that type of administrative
 17 support, and I did that for just over a year.
 18 CHAYTOR, Q.C.:
 19 Q. And other than your BN, do you have any other
 20 educational or continuing education courses?
 21 MS. PREDHAM:
 22 A. In '93 or '94 actually I think it was, I did
 23 the Canadian Hospital Association year-long
 24 program in quality management, and I did some
 25 graduate courses in nursing and then in 2004,

1 Waterford Hospital, and I had that position
 2 until 1996 when I became quality facilitator
 3 with the Health Care Corporation. And I had
 4 that position until 1998, when I became the
 5 risk manager with the Health Care Corporation
 6 and I continued on with that until 2004, when
 7 I became acting director of the Quality and
 8 System Improvement Department, and I held that
 9 position until 2005, towards the end of 2005,
 10 I was the manager of Quality and Risk
 11 Management, and then became the Risk
 12 Management Consultant, Assistant Director,
 13 which I am now.
 14 CHAYTOR, Q.C.:
 15 Q. Okay, and I'm just going to ask you then to
 16 take us through what all of those various
 17 titles might mean. I think we could probably
 18 figure out the front-line psychiatric nurse.
 19 MS. PREDHAM:
 20 A. Okay.
 21 CHAYTOR, Q.C.:
 22 Q. And that's not necessarily relevant to what
 23 we're doing here. I take it though at that
 24 time period, when you worked at the Waterford,
 25 were you a colleague of Peter Dawe at that

1 I started my Masters in Community Health. So
 2 I had the course work for that done. I still
 3 have my thesis to finish.
 4 CHAYTOR, Q.C.:
 5 Q. Okay, and in 19--the course you did, the year-
 6 long course in 1994 in, was it quality
 7 management you said?
 8 MS. PREDHAM:
 9 A. Quality management.
 10 CHAYTOR, Q.C.:
 11 Q. Quality management. Was that a correspondence
 12 course?
 13 MS. PREDHAM:
 14 A. Yes.
 15 CHAYTOR, Q.C.:
 16 Q. Okay, and who offered that course?
 17 MS. PREDHAM:
 18 A. Canadian Hospital Association.
 19 CHAYTOR, Q.C.:
 20 Q. Okay, and what would that course involve?
 21 MS. PREDHAM:
 22 A. Well, that covered over the basis premises of
 23 quality management, you know, CQI, TQ and the
 24 history of it and also covered off components
 25 on risk management, utilization management,

Page 352

1 consumer feedback, a comprehensive course in
 2 quality management.
 3 CHAYTOR, Q.C.:
 4 Q. Okay, so basically the fundamentals of quality
 5 management?
 6 MS. PREDHAM:
 7 A. Exactly.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, and what types of things, for example,
 10 would you--what would you learn through that?
 11 Like what does it mean for us lay people, what
 12 is quality management basically?
 13 MS. PREDHAM:
 14 A. Do you want to know what is quality management
 15 -
 16 CHAYTOR, Q.C.:
 17 Q. Yes.
 18 MS. PREDHAM:
 19 A. - or what I learned?
 20 CHAYTOR, Q.C.:
 21 Q. It's different, is it? Okay. Well tell us
 22 then, what are the fundamentals of quality
 23 management?
 24 MS. PREDHAM:
 25 A. I guess the history of it, how it started off

Page 353

1 with quality assurance, basic quality
 2 assurance, would be auditing and just the
 3 auditing functions that are in a hospital, and
 4 of course, the focus of it all was hospital
 5 based and the other premises are taken from a
 6 lot of work by Edward Demmings, who was an
 7 engineer in the automobile industry. So he
 8 developed TQM, which is total quality
 9 management or CQI, which is continuous quality
 10 improvement. So the concept there was that
 11 you take your audits, you build on the quality
 12 assurance activities, but you go into this
 13 continuous quality improvement of plan, do,
 14 check, act cycle. So you would go into that--
 15 it's a continuous quality improvement, I
 16 guess, is what I'm trying to say, and that you
 17 would plan what you were doing. You would
 18 measure, you would--and you'd keep going. You
 19 keep evaluating there. So that's the basic
 20 premises that you would learn.
 21 Then they would teach you the different
 22 tools. So you'd learn how to do a process
 23 improvement team, how to document using flow
 24 charts, how to document using a fish bone
 25 diagram, a pareto chart, and then you would

Page 354

1 also learn about risk management, how to
 2 investigate an incident, how to utilize
 3 occurrence reporting, so the tools that you
 4 would use in each of those.
 5 Since then, of course, there are other
 6 tools that have been taken from engineering,
 7 such as root cause analysis and a failure mode
 8 effects analysis. So I've done courses in
 9 those as well.
 10 CHAYTOR, Q.C.:
 11 Q. In root cause analysis and failure mode
 12 analysis as well?
 13 MS. PREDHAM:
 14 A. Failure mode effects analysis.
 15 CHAYTOR, Q.C.:
 16 Q. Effects analysis, okay. And is quality
 17 management then different in the health care
 18 setting than it would be in, for example, as
 19 you've given the engineering setting? Is
 20 there any difference in quality management?
 21 MS. PREDHAM:
 22 A. There is--well, it's a slight difference.
 23 It's more with risk management is the bigger
 24 difference, but in quality management, there
 25 is a difference because it's more--in more

Page 355

1 industries, it's more structured and it's the
 2 same every day or you have that more regulated
 3 environment. In hospitals, you tend to have a
 4 lot of activity and a lot of fluctuating
 5 activity, I guess, is a term that I'd like to
 6 use. It is never the same twice. So you may
 7 do something one day, but something subtle
 8 will change to that. So there's nuances that
 9 make it different than another type of
 10 industry. If you're in a more manufacturing
 11 type industry, it's more stagnant. It's the
 12 same type of thing day in and day out.
 13 CHAYTOR, Q.C.:
 14 Q. Okay, and I'll come back probably, leave that
 15 for now and come back because I would like to
 16 explore a little bit more with you as to, you
 17 know, what root cause analysis is and the
 18 other things.
 19 MS. PREDHAM:
 20 A. Sure.
 21 CHAYTOR, Q.C.:
 22 Q. So right now, I'd just like to explore your
 23 background. So you have a BN and you've done
 24 this one-year correspondence course in quality
 25 management.

Page 356

1 MS. PREDHAM:
 2 A. Yes.
 3 CHAYTOR, Q.C.:
 4 Q. And you've done other courses you've said
 5 along the way which included courses that
 6 taught you about root cause analysis. Your
 7 background then in moving to Eastern Health in
 8 1994 or moving to the -
 9 MS. PREDHAM:
 10 A. Health Care Corporation.
 11 CHAYTOR, Q.C.:
 12 Q. - Health Care Corporation at that time, in
 13 1994, and your position at that time was
 14 quality facilitator? Is that correct?
 15 MS. PREDHAM:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And what did that involve, to be a quality
 19 facilitator at Health Care Corp?
 20 MS. PREDHAM:
 21 A. The quality facilitator role was a support
 22 role to the programs. We had--when Health
 23 Care Corporation was set up, they went into
 24 program management. So each of the quality
 25 facilitators were linked to a series of

Page 357

1 programs, a group of programs, and supported
 2 them in developing their goals, their
 3 objectives, their indicators, and we were all
 4 just moving into this process. So one of the
 5 big things we spent a lot of time on were
 6 developing indicators in which they could
 7 monitor, not the routine things that
 8 traditionally areas have monitored, but things
 9 that we can focus in on to improve. So you
 10 know, you'd sit down and you'd look at
 11 turnaround times, wait lists, you know, these
 12 types of things, trying to get the information
 13 for them.
 14 CHAYTOR, Q.C.:
 15 Q. Would you be involved in any education of the
 16 frontline staff as to what it means to have
 17 quality control and quality assurance in
 18 place?
 19 MS. PREDHAM:
 20 A. Yes, we did. We had a day-long session on
 21 quality and quality improvement and that was
 22 broken out into six sessions, I think, on what
 23 is quality, team work, consumer feedback,
 24 utilization management, some of the tools that
 25 you can use.

Page 358

1 CHAYTOR, Q.C.:
 2 Q. And were you responsible for the laboratory
 3 medicine program? Was that one of the
 4 programs you were responsible for?
 5 MS. PREDHAM:
 6 A. Yes, I think, in the beginning, I think in
 7 1996 I was linked to that.
 8 CHAYTOR, Q.C.:
 9 Q. Okay, and for how long? From 1996 until when?
 10 MS. PREDHAM:
 11 A. I think I was only linked with that program
 12 for about a year.
 13 CHAYTOR, Q.C.:
 14 Q. So, perhaps up until 1997?
 15 MS. PREDHAM:
 16 A. Sometime in 1997.
 17 CHAYTOR, Q.C.:
 18 Q. Sometime in 1997, okay. And do you know then
 19 who took over after--so there are different
 20 quality facilitators, I take it, assigned to
 21 different programs.
 22 MS. PREDHAM:
 23 A. Yes.
 24 CHAYTOR, Q.C.:
 25 Q. And do you know who took over then in 1997?

Page 359

1 MS. PREDHAM:
 2 A. I'm not sure. I know later in 1998 after
 3 Nancy Parsons started, she had the lab
 4 program. I can remember that.
 5 CHAYTOR, Q.C.:
 6 Q. Yes and I believe she's told us about that.
 7 MS. PREDHAM:
 8 A. Yes, but I can't remember, and it may be that
 9 I had it until she started in '98.
 10 CHAYTOR, Q.C.:
 11 Q. Okay. And before I move then into your period
 12 of time as risk manager and then onto acting
 13 director, you education--you said that you're
 14 still working on your Masters degree.
 15 MS. PREDHAM:
 16 A. Yes.
 17 CHAYTOR, Q.C.:
 18 Q. And what exactly is it that you're--what is it
 19 that you're doing your Masters--it's a nursing
 20 Masters, I take it?
 21 MS. PREDHAM:
 22 A. No, it's in Community Health actually.
 23 CHAYTOR, Q.C.:
 24 Q. Oh, Community Health, okay.
 25 MS. PREDHAM:

Page 360

1 A. Yes.
 2 CHAYTOR, Q.C.:
 3 Q. And is that at all involved in risk management
 4 or quality management?
 5 MS. PREDHAM:
 6 A. No, but it's much linked to it because you're
 7 learning about qualitative research. You're
 8 doing epidemiology and biostats. So, it has a
 9 lot of--I found it to be a better fit for what
 10 I was actually working at than when I started
 11 doing the nursing degree.
 12 CHAYTOR, Q.C.:
 13 Q. Okay. And does it involve patient safety at
 14 all?
 15 MS. PREDHAM:
 16 A. Well, that's a focus of what my thesis is
 17 going to be because that's my focus of things.
 18 So, projects that I've done as I've went
 19 through that, I've used that as my focus.
 20 CHAYTOR, Q.C.:
 21 Q. And so it is something that fits with what
 22 you're doing in your day-to-day work.
 23 MS. PREDHAM:
 24 A. Yes.
 25 CHAYTOR, Q.C.:

Page 361

1 Q. And so then after--well, the quality
 2 initiatives portfolio that you had and again
 3 remind me, that's 1994 -
 4 MS. PREDHAM:
 5 A. 1996.
 6 CHAYTOR, Q.C.:
 7 Q. '96 through to -
 8 MS. PREDHAM:
 9 A. '98 I became Risk Manager.
 10 CHAYTOR, Q.C.:
 11 Q. '98, okay. And what does it mean then, what's
 12 the difference in moving then into Risk
 13 Manager itself? What were your duties and
 14 responsibilities in 1998 when you took that
 15 on?
 16 MS. PREDHAM:
 17 A. Well, as a quality facilitator, you're linked
 18 with the program, so you're involved. You
 19 screen the occurrence reporting and you're
 20 involved with investigation of incidences, but
 21 when you move into the risk manager position,
 22 you're responsible for occurrence reporting.
 23 So, you're responsible to make sure staff are
 24 educated and that the program works, that the
 25 form needs to be updated or whatever. So,

Page 362

1 you're responsible for co-ordinating that
 2 entire program, getting the reports back to
 3 the program. You're also responsible for
 4 investigating the complaint, liaising with
 5 insurer, with legal counsel.
 6 CHAYTOR, Q.C.:
 7 Q. And that's as the risk manager.
 8 MS. PREDHAM:
 9 A. As the risk manager.
 10 CHAYTOR, Q.C.:
 11 Q. Okay.
 12 MS. PREDHAM:
 13 A. As a quality facilitator you could also end up
 14 linking with the legal counsel, but usually
 15 the contact goes through the risk manager.
 16 CHAYTOR, Q.C.:
 17 Q. Okay. So, you do do investigations of
 18 occurrences or incidences?
 19 MS. PREDHAM:
 20 A. Yes.
 21 CHAYTOR, Q.C.:
 22 Q. And you say you make sure that staff are
 23 educated and when you say the staff, do you
 24 mean the staff within the quality initiatives
 25 department or the staff actually out in the

Page 363

1 programs doing the frontline work?
 2 MS. PREDHAM:
 3 A. Oh no, we do--I've done education sessions on
 4 occurrence reporting to--I don't know how many
 5 staff, but also on different consent policies,
 6 you know, where you go around doing in-
 7 services on consent. And those types of
 8 issues that are higher risk, I guess, types of
 9 procedures then, that's what you would educate
 10 staff on.
 11 CHAYTOR, Q.C.:
 12 Q. Okay. So, staff would include anyone who
 13 worked within -
 14 MS. PREDHAM:
 15 A. Frontline staff.
 16 CHAYTOR, Q.C.:
 17 Q. - any frontline. Would it also include the
 18 physicians?
 19 MS. PREDHAM:
 20 A. At times, depending on the issue. It usually
 21 would be a special session for physicians or
 22 we'd work in something, probably with a VP
 23 medical or with clinical chief. We'd work
 24 around some way to get that information to
 25 them.

Page 364

1 CHAYTOR, Q.C.:

2 Q. Okay. And in this time period, in the late

3 1990's, how well informed were the staff in

4 terms of quality initiatives?

5 MS. PREDHAM:

6 A. From '96 to '98 we did a lot of education for

7 staff because although there was a quality

8 person in each of the legacy boards up to that

9 point, their roles were quite different. At

10 the Waterford my role, majority of my role was

11 responding to patient complaints. So,

12 although I was following up on occurrence

13 reports and that type of thing, that was the

14 primary focus of my role. So, if frontline

15 staff in the mental health program saw me,

16 that's what they would think first and the

17 same with the different legacy organizations.

18 So, we had to do a lot of education on what

19 type of thing that quality initiatives would

20 do. But the other thing that's very important

21 for frontline staff to know what we're doing

22 is because we can't be everywhere. We have to

23 rely on them to tell us what's happening out

24 there.

25 CHAYTOR, Q.C.:

Page 365

1 Q. And to feel comfortable in telling you.

2 MS. PREDHAM:

3 A. Exactly.

4 CHAYTOR, Q.C.:

5 Q. Feel comfortable in reporting an incident or

6 something they see as being dangerous or less

7 than optimal.

8 MS. PREDHAM:

9 A. Exactly. And when we came together as the

10 Health Care Corporation, we--two of the

11 previous sites had very punitive form of

12 occurrence reporting. So, that was another

13 challenge that we had to deal with. So, we

14 had to get that message across that occurrence

15 reporting is non punitive, but we also had to,

16 I guess, walk the walk, for the better way of

17 putting it. We had to go through that process

18 and say that, you know, you are not getting in

19 trouble because you filled these out. So, we

20 had to get examples and show them how this is

21 so beneficial to us. These are the things

22 that we've learned from occurrence reporting.

23 If nobody reported this, we wouldn't know

24 about it; we wouldn't be able to deal with it.

25 So, it was really important to get that

Page 366

1 message out there.

2 CHAYTOR, Q.C.:

3 Q. So, I guess in getting the report, not only

4 would you investigate that particular incident

5 and look for whatever may have contributed to

6 the incident, would you then keep track and

7 keep that in some sort of database or

8 otherwise keep it so that you could follow any

9 trends of similar instances that may arise?

10 MS. PREDHAM:

11 A. Yes, and that was a big challenge when we

12 first started. We were doing it manually when

13 we first started. So, tallying up to, I think

14 it was--we were probably getting 3 to 4000

15 occurrence reports a year. So, internally,

16 our IT department was able to do a front end

17 reporting mechanism. So, the quality

18 facilitators would take the occurrence

19 reports, we'd code them and then enter it all

20 into this database. But then we had to

21 download the information into Excel and format

22 it into a report to quarterly get back to the

23 programs to say these are the types of things

24 that you're reporting. So beyond the

25 individual follow up for occurrences, we had

Page 367

1 to do this trending as well.

2 CHAYTOR, Q.C.:

3 Q. Okay, and then you'd give feedback on a

4 quarterly basis to the various programs.

5 MS. PREDHAM:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. For anything that you were seeing in terms of

9 trends or types of incidences that were being

10 -

11 MS. PREDHAM:

12 A. Well they give a summary of all their

13 occurrences, so they would say over this

14 quarter you had these many medication

15 occurrences, these many files, this many

16 property loss, you know, that type of thing.

17 And then annually we would do that as well.

18 CHAYTOR, Q.C.:

19 Q. And if there is anything that you saw or that

20 caused you concern that there was a trend,

21 well whose attention would you then bring that

22 to?

23 MS. PREDHAM:

24 A. Well it would depend on the type of

25 occurrence. If it was anything--we had one

Page 368

1 trend that we picked up fairly quickly with a
 2 certain type of suction machine that we had
 3 and we had to get a large group of people,
 4 because that was throughout the organization,
 5 but it was because we were trending the
 6 occurrences that we picked up that we had an
 7 issue, because we had an issue in DI,
 8 diagnostic imaging, we had an issue on a
 9 surgery floor, we had an issue on the medicine
 10 floor and we had an issue in critical care.
 11 So they were very similar and because they
 12 were similar, we picked up that trend and then
 13 it was a very broad base group that had to get
 14 together to deal with that.

15 CHAYTOR, Q.C.:
 16 Q. And then you were able to track it back to the
 17 -

18 MS. PREDHAM:
 19 A. It was the--fundamentally it was a new suction
 20 device that we were using and the way that it
 21 had a backflow valve in it. The way we were
 22 using it was causing this problem and an
 23 interruption in the suction, so we actually
 24 had to cancel the tender with this one and go
 25 back to another version that we were using

Page 369

1 because to change practice, it would have been
 2 too difficult to ensure that that machine
 3 could keep working.

4 CHAYTOR, Q.C.:
 5 Q. And so that's a good concrete example of how
 6 somebody filling out the occurrence report and
 7 having it come to a centralized location and
 8 having the trends followed, could then pick up
 9 on the issues and enhance patient care and
 10 safety.

11 MS. PREDHAM:
 12 A. Exactly.

13 CHAYTOR, Q.C.:
 14 Q. First of all I should ask you, where were you
 15 when you first came over to Health Care
 16 Corporation in 1996, where were you physically
 17 located?

18 MS. PREDHAM:
 19 A. At that time our department centrally had an
 20 office at St. Clare's, but each of the quality
 21 facilitators had two offices, so I had an
 22 office at the Waterford and an office at St.
 23 Clare's because I was--we had a transition
 24 period going in through the Health Care
 25 Corporation where the programs had not been

Page 370

1 established yet, but the quality initiatives
 2 department had, so when we originally started,
 3 we were linked to sites. So I was linked to
 4 the St. Clare's site and the Waterford site.
 5 Another quality facilitator was linked to the
 6 Health Sciences site and the Grace and another
 7 one was the Janeway and somewhere else--I
 8 can't think of where else it was. But we had
 9 a central office then at St. Clare's.

10 CHAYTOR, Q.C.:
 11 Q. Okay, and when you became risk manager, where
 12 were you physically then located?

13 MS. PREDHAM:
 14 A. Well coincidentally, just when I became risk
 15 manager, we moved our entire office at the
 16 Waterford, so I was at the Waterford site.

17 CHAYTOR, Q.C.:
 18 Q. Okay, and you remained then in the risk
 19 management position from 1998 until 2004, is
 20 that correct.

21 MS. PREDHAM:
 22 A. 2004.

23 CHAYTOR, Q.C.:
 24 Q. And then you became acting director--what was
 25 the name of your title?

Page 371

1 MS. PREDHAM:
 2 A. Well again, coincidentally, our department
 3 changed just before I became acting director
 4 and we merged with the Management and
 5 Engineering Department. In Quality
 6 Initiatives, besides the quality facilitator,
 7 utilization manager and the director, we also
 8 had an infection control division reported to
 9 us, so when we became Quality and Systems
 10 Improvement, we had three divisions, so our
 11 department changed slightly and became--we had
 12 a management engineering division, the quality
 13 and risk management division and infection
 14 control division.

15 CHAYTOR, Q.C.:
 16 Q. And that was as of 2004?

17 MS. PREDHAM:
 18 A. 2004.

19 CHAYTOR, Q.C.:
 20 Q. And that continued until when?

21 MS. PREDHAM:
 22 A. That continued until, I think in the summer of
 23 2005, management engineering reported to
 24 planning and research with the formation of
 25 Eastern Health, they moved over there.

Page 372

1 Infection control has just now become a
 2 division of their own with their own director.
 3 CHAYTOR, Q.C.:
 4 Q. And so then you remained in your acting
 5 director capacity until when?
 6 MS. PREDHAM:
 7 A. October of 2005.
 8 CHAYTOR, Q.C.:
 9 Q. October of 2005. And then in October, 2005,
 10 you became -
 11 MS. PREDHAM:
 12 A. I went back to the manager of quality and
 13 risk, which was--it was the risk manager
 14 position, I guess, but because we changed at
 15 that time to the three division format of our
 16 department, it was the manager of quality and
 17 risk, so the quality facilitators reported to
 18 the previous position of a risk manager.
 19 CHAYTOR, Q.C.:
 20 Q. So in 1998 when you were risk manager, the
 21 quality facilitators were reporting -
 22 MS. PREDHAM:
 23 A. No, they were reporting to the director.
 24 CHAYTOR, Q.C.:
 25 Q. They were reporting to the director, not to

Page 373

1 you.
 2 MS. PREDHAM:
 3 A. No.
 4 CHAYTOR, Q.C.:
 5 Q. And when you became the manager of quality and
 6 risk in the fall of 2005, then the quality
 7 facilitators were reporting to you?
 8 MS. PREDHAM:
 9 A. Yes.
 10 THE COMMISSIONER:
 11 Q. Wait now, what was your title in 2004? I
 12 thought you became acting director of quality
 13 and risk management.
 14 MS. PREDHAM:
 15 A. Of quality and system improvement.
 16 THE COMMISSIONER:
 17 Q. Quality and system, oh, sorry. But then in
 18 2005, you were manager of quality and risk
 19 management.
 20 MS. PREDHAM:
 21 A. Quality and risk management. That was a
 22 division in the quality and system improvement
 23 department.
 24 THE COMMISSIONER:
 25 Q. Okay.

Page 374

1 CHAYTOR, Q.C.:
 2 Q. So when you became the manager of quality and
 3 risk in the fall of 2005, was that in essence
 4 the same position that you held as risk
 5 manager?
 6 MS. PREDHAM:
 7 A. Other than the quality facilitators reported
 8 to me, it was.
 9 CHAYTOR, Q.C.:
 10 Q. So you had all the same duties in terms of
 11 making sure the staff were educated, making
 12 sure that incidents were being reported,
 13 liaisoning with the insurer or lawyers and
 14 investigating incidents, all of those same
 15 duties, plus then you had the quality
 16 facilitators reporting to you?
 17 MS. PREDHAM:
 18 A. Yes.
 19 CHAYTOR, Q.C.:
 20 Q. And that's the position that you still hold?
 21 MS. PREDHAM:
 22 A. No. Sorry.
 23 CHAYTOR, Q.C.:
 24 Q. Do you have a C.V.?
 25 MS. PREDHAM:

Page 375

1 A. Yes, I do.
 2 CHAYTOR, Q.C.:
 3 Q. We have a C.V. okay.
 4 MS. PREDHAM:
 5 A. In June of 2006, because see, we were becoming
 6 Eastern Health--I was acting director until
 7 Pam Elliott started as director of quality and
 8 risk management.
 9 CHAYTOR, Q.C.:
 10 Q. Yes.
 11 MS. PREDHAM:
 12 A. And that was October 31st, 2005. So after
 13 that, we didn't have a structure for a
 14 department, so I had to go back to my old
 15 position which had changed, slightly different
 16 position. So then when the department
 17 positions got developed, then I became the
 18 risk management consultant and assistant
 19 director. So after Ms. Elliott started, the
 20 whole department changed because it was a
 21 regional department then.
 22 CHAYTOR, Q.C.:
 23 Q. Okay, and perhaps then what we can do,
 24 Commissioner, is we'll find the C.V. and if we
 25 could take it up from there tomorrow and you

Page 376

1 could tell us about how the department changed
2 when Ms. Elliott came along into the position.
3 THE COMMISSIONER:
4 Q. All right. I'm sorry we were so late getting
5 on with you, but I felt it was worthwhile
6 using this half hour to try and straighten out
7 your history. Thank you. 9:30 in the
8 morning.

Page 377

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 15th day of October, A.D., 2008 before
6 the Honourable Justice Margaret A. Cameron,
7 Commissioner, at the Commission of Inquiry, St.
8 John's, Newfoundland and Labrador and was
9 transcribed by me to the best of my ability by
10 means of a sound apparatus.
11 Dated at St. John's, Newfoundland and Labrador
12 this 15th day of October, A.D., 2008
13 Judy Moss

Inquiry on Hormone Receptor Testing

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<p>-&-</p> <p>& [6] 24:8 30:4,8 188:21 242:24 244:4</p>	<p>-'-</p> <p>'01 [2] 222:14,24 '04 [4] 57:15 168:9 174:13,15 '05 [8] 83:22 85:16 113:4 168:9 174:15 248:6 300:16 301:13 '07 [6] 73:21 109:23 110:10 118:11 119:21 266:18 '08 [1] 301:2 '80's [1] 219:17 '80s [1] 257:16 '87 [2] 23:14 277:24 '93 [1] 350:22 '94 [1] 350:22 '96 [3] 195:6 361:7 364:6 '97 [20] 137:17 175:20,25 184:11 195:6 208:2 212:7 212:18 221:19 222:11,14 222:18,22,24 228:1 240:18 246:25 277:22 300:13 315:1 '97/'98 [1] 18:12 '98 [9] 17:4 52:1,11 208:3 222:11 359:9 361:9,11 364:6 '99 [9] 17:4 208:3,16,19 217:5 222:12 223:17 233:10 273:24</p>	<p>-2-</p> <p>2 [7] 123:21 124:12 230:25 234:19 297:2,3 300:23 20 [12] 12:12 47:19 50:8 50:14 123:18 134:21 135:1,4,15 205:22 241:25 342:25 20,000 [2] 199:19 200:10 200 [3] 96:19,24 319:21 2000 [16] 17:4 51:11 78:11,22 79:23 80:22 96:7,9,25 97:10 99:10 137:17 171:15 222:12 223:7 330:5 2001 [9] 13:23 14:1 221:19,21 222:11,18 278:15,18,21 2001/2002 [1] 42:22 2002 [9] 88:20,22,25 140:22 171:15 223:9,11 223:19 343:2 2003 [16] 18:11 48:24 51:5,11 52:20 53:17 59:3 60:7,12 61:20 213:1 285:10,13 286:9 308:18 342:25 2003/2004 [1] 53:19 2004 [17] 67:5 142:6,12 143:4 167:1 169:9 172:5 172:23 174:24 247:1 349:6 350:25 370:19,22 371:16,18 373:11 2005 [49] 15:16 25:20 36:8 57:11 69:24 72:24 73:7,11,23 75:21 77:1 77:13,15 85:5 102:14 113:6 129:15 167:18 174:5,7,25 213:2 217:21 220:15 222:3,9 245:17 245:24 273:1 277:18 300:2,13 313:6 314:14 316:14,19,24 317:5 335:12 349:9,9 371:23 372:7,9,9 373:6,18 374:3 375:12</p>	<p>-3-</p> <p>3 [5] 99:2 102:4,17 232:17 366:14 3.4 [1] 38:7 30 [23] 35:19,22 40:5,16 41:1,20,22 42:13 84:18 137:18 177:8 203:10 282:19 283:8,12,16 299:6 299:20 329:15,24 330:9 333:7 344:10 30/40 [1] 114:14 300 [1] 77:23 3000 [12] 77:17 78:2,4 78:20,20 79:19 300:10 300:11,20 301:15 302:9 304:23 303 [3] 319:24 320:13,15 304 [2] 319:24 320:13 3040 [1] 346:21 3059 [1] 346:24 3078 [1] 346:25 3100 [2] 266:17 269:9</p>	<p>-4-</p> <p>4 [1] 2:3 40 [6] 84:18 134:22,24 135:14 141:23 335:11 40-50 [4] 131:11 135:14 141:5 165:15 400 [3] 169:19,24 170:18 4000 [1] 366:14 413 [1] 134:18 42 [2] 86:6 169:8 44 [1] 298:9 46.3 [1] 282:14 4th [1] 167:18</p>
<p>---</p> <p>-here [1] 339:9 -they [1] 150:12 -yes [1] 67:7</p> <p>-0-</p> <p>0 [5] 123:22 124:12 125:12,13,13 0/0 [3] 114:15,18 115:8 0079 [1] 246:12 0264 [1] 347:5 0720 [1] 134:1</p>	<p>-1-</p> <p>1 [3] 99:2 102:4,16 1,529 [1] 170:23 10 [8] 97:3 107:23 134:21 199:19 209:2 299:6</p>	<p>-2-</p> <p>2 [7] 123:21 124:12 230:25 234:19 297:2,3 300:23 20 [12] 12:12 47:19 50:8 50:14 123:18 134:21 135:1,4,15 205:22 241:25 342:25 20,000 [2] 199:19 200:10 200 [3] 96:19,24 319:21 2000 [16] 17:4 51:11 78:11,22 79:23 80:22 96:7,9,25 97:10 99:10 137:17 171:15 222:12 223:7 330:5 2001 [9] 13:23 14:1 221:19,21 222:11,18 278:15,18,21 2001/2002 [1] 42:22 2002 [9] 88:20,22,25 140:22 171:15 223:9,11 223:19 343:2 2003 [16] 18:11 48:24 51:5,11 52:20 53:17 59:3 60:7,12 61:20 213:1 285:10,13 286:9 308:18 342:25 2003/2004 [1] 53:19 2004 [17] 67:5 142:6,12 143:4 167:1 169:9 172:5 172:23 174:24 247:1 349:6 350:25 370:19,22 371:16,18 373:11 2005 [49] 15:16 25:20 36:8 57:11 69:24 72:24 73:7,11,23 75:21 77:1 77:13,15 85:5 102:14 113:6 129:15 167:18 174:5,7,25 213:2 217:21 220:15 222:3,9 245:17 245:24 273:1 277:18 300:2,13 313:6 314:14 316:14,19,24 317:5 335:12 349:9,9 371:23 372:7,9,9 373:6,18 374:3 375:12</p>	<p>-3-</p> <p>3 [5] 99:2 102:4,17 232:17 366:14 3.4 [1] 38:7 30 [23] 35:19,22 40:5,16 41:1,20,22 42:13 84:18 137:18 177:8 203:10 282:19 283:8,12,16 299:6 299:20 329:15,24 330:9 333:7 344:10 30/40 [1] 114:14 300 [1] 77:23 3000 [12] 77:17 78:2,4 78:20,20 79:19 300:10 300:11,20 301:15 302:9 304:23 303 [3] 319:24 320:13,15 304 [2] 319:24 320:13 3040 [1] 346:21 3059 [1] 346:24 3078 [1] 346:25 3100 [2] 266:17 269:9</p>	<p>-5-</p> <p>5 [5] 206:19,21 207:6 285:5,7 50 [8] 107:18 134:22 146:11 283:8 332:8,9 341:16,21 50-60 [2] 129:3 132:15 50/60 [1] 125:13 500 [2] 56:24 334:18 50s [1] 324:13 520 [1] 134:23 53 [7] 265:7,11 266:11 269:14 270:5,10 273:13 53.7 [1] 282:14 5th [1] 167:18</p>
<p>-1-</p> <p>1 [3] 99:2 102:4,16 1,529 [1] 170:23 10 [8] 97:3 107:23 134:21 199:19 209:2 299:6</p>	<p>-1-</p> <p>1 [3] 99:2 102:4,16 1,529 [1] 170:23 10 [8] 97:3 107:23 134:21 199:19 209:2 299:6</p>	<p>-2-</p> <p>2 [7] 123:21 124:12 230:25 234:19 297:2,3 300:23 20 [12] 12:12 47:19 50:8 50:14 123:18 134:21 135:1,4,15 205:22 241:25 342:25 20,000 [2] 199:19 200:10 200 [3] 96:19,24 319:21 2000 [16] 17:4 51:11 78:11,22 79:23 80:22 96:7,9,25 97:10 99:10 137:17 171:15 222:12 223:7 330:5 2001 [9] 13:23 14:1 221:19,21 222:11,18 278:15,18,21 2001/2002 [1] 42:22 2002 [9] 88:20,22,25 140:22 171:15 223:9,11 223:19 343:2 2003 [16] 18:11 48:24 51:5,11 52:20 53:17 59:3 60:7,12 61:20 213:1 285:10,13 286:9 308:18 342:25 2003/2004 [1] 53:19 2004 [17] 67:5 142:6,12 143:4 167:1 169:9 172:5 172:23 174:24 247:1 349:6 350:25 370:19,22 371:16,18 373:11 2005 [49] 15:16 25:20 36:8 57:11 69:24 72:24 73:7,11,23 75:21 77:1 77:13,15 85:5 102:14 113:6 129:15 167:18 174:5,7,25 213:2 217:21 220:15 222:3,9 245:17 245:24 273:1 277:18 300:2,13 313:6 314:14 316:14,19,24 317:5 335:12 349:9,9 371:23 372:7,9,9 373:6,18 374:3 375:12</p>	<p>-3-</p> <p>3 [5] 99:2 102:4,17 232:17 366:14 3.4 [1] 38:7 30 [23] 35:19,22 40:5,16 41:1,20,22 42:13 84:18 137:18 177:8 203:10 282:19 283:8,12,16 299:6 299:20 329:15,24 330:9 333:7 344:10 30/40 [1] 114:14 300 [1] 77:23 3000 [12] 77:17 78:2,4 78:20,20 79:19 300:10 300:11,20 301:15 302:9 304:23 303 [3] 319:24 320:13,15 304 [2] 319:24 320:13 3040 [1] 346:21 3059 [1] 346:24 3078 [1] 346:25 3100 [2] 266:17 269:9</p>	<p>-6-</p> <p>6 [1] 297:3 60 [6] 88:24 107:18 131:3 146:11 332:9,9 60-70 [2] 131:13 165:15 61 [3] 124:20,22 125:12 615 [1] 134:25 65 [1] 297:6 67 [2] 282:18,18 68 [2] 135:4 171:17</p>

<p>6th [1] 274:21</p> <hr/> <p style="text-align: center;">-7-</p> <hr/> <p>7 [1] 279:20 7.0 [1] 51:3 70 [5] 107:18 144:6 171:17 282:17,18 717 [1] 131:2 72 [2] 2:3,4 720 [1] 123:15 74 [7] 263:20 264:12 265:17 268:9,18 270:11 297:10 75 [7] 123:21 124:11 145:9,13 264:8 279:19 297:6 763 [3] 98:3,8,11 767 [1] 131:11 77 [1] 170:25 778 [1] 134:21 78 [1] 273:15 78.3 [3] 267:8 269:12 270:4 7th [2] 282:2 320:1</p>	<p>accepted [1] 159:24 accepting [1] 171:13 access [9] 61:16 90:11 90:22 91:6,15,22 117:6 159:3 272:14 accommodate [2] 53:10 58:3 accomplish [1] 225:2 according [1] 99:7 account [7] 172:7,15 291:20,23 292:16,21 293:3 accountability [1] 204:11 accreditation [3] 21:18 67:5 311:1 accuracy [4] 5:20,24 67:10 255:17 accurate [8] 84:23 97:12 132:9 144:2 163:18 194:11 293:3 300:3 accurately [1] 235:9 achieve [4] 201:21 225:12 318:18 337:17 acknowledged [2] 131:16 311:15</p>	<p>address [6] 192:19 292:14 295:10 314:23 325:18 326:17 addressed [10] 59:9 235:5 285:14,18 286:17 287:4,8,9 291:15 328:1 addresses [1] 314:15 adequate [3] 186:21 323:5,9 adequately [4] 213:16 288:22 322:10 324:1 ADJOURNED [1] 224:21 adjust [2] 172:14 175:9 adjusted [2] 166:22 172:7 administration [1] 19:2 administrative [10] 66:8 77:6 187:22 188:15 189:21 204:9 253:18 280:15 350:13,16 administrator [1] 335:1 adopt [1] 229:9 adopted [2] 238:14 300:10 advanced [1] 256:19 advancement [1] 290:14 advances [2] 21:21 256:14 advice [3] 198:10 239:21 248:20 advise [1] 288:16 advised [1] 297:9 affect [1] 274:18 affected [9] 77:23 142:3 143:12 147:14 300:4 303:2,4,8 335:25 affidavit [5] 268:8,8,10 270:11 297:1 afternoon [4] 291:4 346:2,4,11 afterwards [2] 221:25 250:4 again [104] 8:25 12:17 13:18,23,25,25 14:1 17:20 18:1,12 21:12 26:22 30:9 31:13 32:9 37:10,18,20,22 38:19 39:5 46:4,11 47:22 50:10 51:12 52:16 55:24 56:10 58:3 60:5 62:6 64:10,24 66:2,15 67:15 68:17 110:10 115:11 117:2 120:9,11 124:20 125:16 126:11,20 131:6 132:7 132:13,20 138:15 139:6 140:13 145:25 147:21 149:16 151:6 153:11 158:1 160:18 164:18 166:2 167:5,25 169:4 173:4 175:23 176:17 177:4 179:15 180:5,17 181:1 190:10 192:9 193:10,15 220:7 228:15 235:2 244:4 245:5 251:13 256:11 262:21 269:17</p>	<p>270:13 277:18 282:24 284:17 286:19 293:25 301:1 304:22 308:6 311:23 313:1 324:4 325:25 328:8 329:23 361:2 371:2 against [5] 56:21 58:5 234:25 247:21 272:2 age [1] 128:16 agencies [1] 67:10 ago [10] 4:18 32:10 37:16 177:23 191:18,19 235:3 267:3 321:10 325:4 agree [17] 29:1 30:22 34:14 57:5 188:4 194:2 206:4,14 207:10,16 231:16 254:6 281:17 298:13 312:5 317:6 322:11 agreed [2] 37:6 270:6 agreement [5] 29:8 53:22 264:23 265:23 292:12 ahead [3] 57:14 194:13 276:16 aid [1] 183:18 al [1] 1:9 alarm [1] 243:6 Alberta [1] 19:5 alert [1] 204:19 allay [1] 55:20 allocation [1] 153:3 allow [1] 239:24 alluding [1] 92:15 almost [9] 28:24 77:17 222:21,22 252:3 273:17 304:23 322:18 350:12 alone [1] 206:4 along [13] 12:10 17:8 18:1 44:5 120:13 193:6 211:1 232:17 263:3 265:21 296:19 356:5 376:2 alongside [1] 255:16 always [5] 229:4 239:23 243:19 258:14 344:10 America [1] 256:17 among [5] 36:9 37:5 41:19 295:21 333:4 amount [8] 16:20 121:18 179:8 201:13 257:23 291:1 335:19 337:3 analyses [2] 298:24 299:16 analysis [21] 86:10 91:9 117:16 119:13 120:17 158:22 160:7,23 161:4 177:5 298:15 313:4 324:22 354:7,8,11,12,14 354:16 355:17 356:6 analyzed [1] 297:7 anatomical [1] 187:9 anguish [1] 335:24 annually [1] 367:17 answer [42] 25:10 46:11</p>	<p>74:22 93:14 132:10,20 205:21 213:6 224:2 228:23 230:13,19 235:8 235:13 236:23 258:23,25 259:1 260:7,14 272:8,10 278:18,23 279:10,25 280:4,6,9 284:10 296:15 315:15 318:19 325:23 326:5,7,8,12 327:13,14 327:17 342:5 answered [1] 251:14 answers [5] 4:12 233:22 236:25 298:3 338:14 Anthony [1] 121:10 anti [1] 226:18 antibodies [21] 11:18 33:9 183:16 187:16,17 199:12,13,16 225:5 236:7 236:7 237:10,19 239:7,9 245:5 247:21 248:9 254:23 257:4 316:10 antibody [19] 31:20 32:1 32:7,18 33:20 34:11 104:10 199:3 251:25 252:3,9 253:20,25 238:3,6 340:16 341:3,6,13 342:1 343:11 anticipate [1] 95:20 antigen [20] 11:13,15,19 104:23 225:1,5,12,13,24 228:13 233:25 235:16 236:3 237:20,25 238:3,6 239:7 259:5 260:8 antigens [1] 182:12 anyway [3] 127:10 192:22 309:14 apologies [1] 36:18 apologize [2] 38:7 207:2 apparatus [1] 377:10 apparent [1] 135:24 appear [3] 93:17 132:16 147:5 Appearances [1] 1:5 appeared [2] 223:20 297:5 appended [1] 261:10 appendix [2] 260:16 338:14 applied [4] 236:3 237:20 239:8 332:11 applies [2] 4:25 262:4 apply [6] 127:6 203:19 226:13 240:11 252:2 256:21 applying [2] 251:24 252:3 appointed [1] 216:21 appraisal [1] 295:1 appreciate [7] 41:13 63:21 192:25 193:8 194:3 244:11 344:20 appreciated [1] 198:10 approach [2] 29:18 300:10 appropriate [7] 18:12 83:15 200:9 265:14,16</p>
<p style="text-align: center;">-8-</p> <hr/> <p>80 [1] 169:5 804 [2] 134:20,21 80s [2] 179:24 256:24 827 [1] 131:12 86 [3] 167:16,23 169:3 89 [1] 167:2</p>	<p>acquire [1] 290:19 acquired [1] 232:23 acquisition [1] 232:22 act [1] 353:14 acted [2] 295:2,2 acting [8] 216:13 349:7 359:12 370:24 371:3 372:4 373:12 375:6 action [6] 1:13 75:16 102:20 111:7 178:9 291:17 active [1] 198:18 actively [2] 120:11 195:20 activities [1] 353:12 activity [3] 288:6 355:4 355:5 actual [17] 82:8 90:16 92:18 98:16 100:5 104:9 139:17 155:10 195:25 198:24 236:5,8 237:18 295:1 316:8 339:16 343:20 adalin [1] 45:25 add [10] 9:22 50:14,16 115:24 116:2 120:24 121:1 190:9 257:8 316:9 added [11] 50:2,18 152:16 172:10 174:17 187:17 190:11 236:6,6,7 336:20 addendum [2] 25:25 26:21 adding [5] 155:2,19,23 199:11,16 addition [1] 135:19 additional [8] 106:19 199:17 289:16 290:4 315:22 317:3 319:5 336:1</p>	<p>advanced [1] 256:19 advancement [1] 290:14 advances [2] 21:21 256:14 advice [3] 198:10 239:21 248:20 advise [1] 288:16 advised [1] 297:9 affect [1] 274:18 affected [9] 77:23 142:3 143:12 147:14 300:4 303:2,4,8 335:25 affidavit [5] 268:8,8,10 270:11 297:1 afternoon [4] 291:4 346:2,4,11 afterwards [2] 221:25 250:4 again [104] 8:25 12:17 13:18,23,25,25 14:1 17:20 18:1,12 21:12 26:22 30:9 31:13 32:9 37:10,18,20,22 38:19 39:5 46:4,11 47:22 50:10 51:12 52:16 55:24 56:10 58:3 60:5 62:6 64:10,24 66:2,15 67:15 68:17 110:10 115:11 117:2 120:9,11 124:20 125:16 126:11,20 131:6 132:7 132:13,20 138:15 139:6 140:13 145:25 147:21 149:16 151:6 153:11 158:1 160:18 164:18 166:2 167:5,25 169:4 173:4 175:23 176:17 177:4 179:15 180:5,17 181:1 190:10 192:9 193:10,15 220:7 228:15 235:2 244:4 245:5 251:13 256:11 262:21 269:17</p>	<p>270:13 277:18 282:24 284:17 286:19 293:25 301:1 304:22 308:6 311:23 313:1 324:4 325:25 328:8 329:23 361:2 371:2 against [5] 56:21 58:5 234:25 247:21 272:2 age [1] 128:16 agencies [1] 67:10 ago [10] 4:18 32:10 37:16 177:23 191:18,19 235:3 267:3 321:10 325:4 agree [17] 29:1 30:22 34:14 57:5 188:4 194:2 206:4,14 207:10,16 231:16 254:6 281:17 298:13 312:5 317:6 322:11 agreed [2] 37:6 270:6 agreement [5] 29:8 53:22 264:23 265:23 292:12 ahead [3] 57:14 194:13 276:16 aid [1] 183:18 al [1] 1:9 alarm [1] 243:6 Alberta [1] 19:5 alert [1] 204:19 allay [1] 55:20 allocation [1] 153:3 allow [1] 239:24 alluding [1] 92:15 almost [9] 28:24 77:17 222:21,22 252:3 273:17 304:23 322:18 350:12 alone [1] 206:4 along [13] 12:10 17:8 18:1 44:5 120:13 193:6 211:1 232:17 263:3 265:21 296:19 356:5 376:2 alongside [1] 255:16 always [5] 229:4 239:23 243:19 258:14 344:10 America [1] 256:17 among [5] 36:9 37:5 41:19 295:21 333:4 amount [8] 16:20 121:18 179:8 201:13 257:23 291:1 335:19 337:3 analyses [2] 298:24 299:16 analysis [21] 86:10 91:9 117:16 119:13 120:17 158:22 160:7,23 161:4 177:5 298:15 313:4 324:22 354:7,8,11,12,14 354:16 355:17 356:6 analyzed [1] 297:7 anatomical [1] 187:9 anguish [1] 335:24 annually [1] 367:17 answer [42] 25:10 46:11</p>	<p>74:22 93:14 132:10,20 205:21 213:6 224:2 228:23 230:13,19 235:8 235:13 236:23 258:23,25 259:1 260:7,14 272:8,10 278:18,23 279:10,25 280:4,6,9 284:10 296:15 315:15 318:19 325:23 326:5,7,8,12 327:13,14 327:17 342:5 answered [1] 251:14 answers [5] 4:12 233:22 236:25 298:3 338:14 Anthony [1] 121:10 anti [1] 226:18 antibodies [21] 11:18 33:9 183:16 187:16,17 199:12,13,16 225:5 236:7 236:7 237:10,19 239:7,9 245:5 247:21 248:9 254:23 257:4 316:10 antibody [19] 31:20 32:1 32:7,18 33:20 34:11 104:10 199:3 251:25 252:3,9 253:20,25 238:3,6 340:16 341:3,6,13 342:1 343:11 anticipate [1] 95:20 antigen [20] 11:13,15,19 104:23 225:1,5,12,13,24 228:13 233:25 235:16 236:3 237:20,25 238:3,6 239:7 259:5 260:8 antigens [1] 182:12 anyway [3] 127:10 192:22 309:14 apologies [1] 36:18 apologize [2] 38:7 207:2 apparatus [1] 377:10 apparent [1] 135:24 appear [3] 93:17 132:16 147:5 Appearances [1] 1:5 appeared [2] 223:20 297:5 appended [1] 261:10 appendix [2] 260:16 338:14 applied [4] 236:3 237:20 239:8 332:11 applies [2] 4:25 262:4 apply [6] 127:6 203:19 226:13 240:11 252:2 256:21 applying [2] 251:24 252:3 appointed [1] 216:21 appraisal [1] 295:1 appreciate [7] 41:13 63:21 192:25 193:8 194:3 244:11 344:20 appreciated [1] 198:10 approach [2] 29:18 300:10 appropriate [7] 18:12 83:15 200:9 265:14,16</p>
<p style="text-align: center;">-A-</p> <hr/> <p>A.D [2] 377:5,12 abandoned [2] 236:16 236:18 ability [2] 63:14 377:9 able [19] 60:25 61:6 64:2 91:12 116:19 119:22 147:22 151:23 176:13 198:4 232:11,16 251:2 290:18 311:6,7 365:24 366:16 368:16 above [5] 131:16 234:24 266:1 332:10 336:17 absence [3] 219:9 262:18 312:2 absent [1] 312:8 accept [2] 203:12 325:8 acceptable [1] 315:15</p>	<p>accepted [1] 159:24 accepting [1] 171:13 access [9] 61:16 90:11 90:22 91:6,15,22 117:6 159:3 272:14 accommodate [2] 53:10 58:3 accomplish [1] 225:2 according [1] 99:7 account [7] 172:7,15 291:20,23 292:16,21 293:3 accountability [1] 204:11 accreditation [3] 21:18 67:5 311:1 accuracy [4] 5:20,24 67:10 255:17 accurate [8] 84:23 97:12 132:9 144:2 163:18 194:11 293:3 300:3 accurately [1] 235:9 achieve [4] 201:21 225:12 318:18 337:17 acknowledged [2] 131:16 311:15 acquire [1] 290:19 acquired [1] 232:23 acquisition [1] 232:22 act [1] 353:14 acted [2] 295:2,2 acting [8] 216:13 349:7 359:12 370:24 371:3 372:4 373:12 375:6 action [6] 1:13 75:16 102:20 111:7 178:9 291:17 active [1] 198:18 actively [2] 120:11 195:20 activities [1] 353:12 activity [3] 288:6 355:4 355:5 actual [17] 82:8 90:16 92:18 98:16 100:5 104:9 139:17 155:10 195:25 198:24 236:5,8 237:18 295:1 316:8 339:16 343:20 adalin [1] 45:25 add [10] 9:22 50:14,16 115:24 116:2 120:24 121:1 190:9 257:8 316:9 added [11] 50:2,18 152:16 172:10 174:17 187:17 190:11 236:6,6,7 336:20 addendum [2] 25:25 26:21 adding [5] 155:2,19,23 199:11,16 addition [1] 135:19 additional [8] 106:19 199:17 289:16 290:4 315:22 317:3 319:5 336:1</p>	<p>address [6] 192:19 292:14 295:10 314:23 325:18 326:17 addressed [10] 59:9 235:5 285:14,18 286:17 287:4,8,9 291:15 328:1 addresses [1] 314:15 adequate [3] 186:21 3</p>		

<p>265:18 296:13 appropriately [1] 296:19 approval [2] 190:10 314:17 approximate [2] 96:25 301:15 April [11] 59:2,4 167:18 168:9,11 174:13,14,17 174:24 285:13 324:7 area [4] 21:11 34:16 283:8 348:24 areas [3] 115:22,22 357:8 arise [1] 366:9 arising [1] 338:3 arm [1] 66:1 arose [1] 338:8 arrive [1] 264:18 arrived [1] 35:22 arrives [1] 265:17 arriving [3] 263:15 264:12 297:24 article [3] 76:2 77:14 79:18 articles [1] 73:16 ASAP [1] 68:2 ascertain [2] 104:5 191:11 aside [7] 32:16 63:6 64:15 82:20 83:2 155:1 331:17 asks [1] 26:17 aspects [1] 44:13 assay [16] 33:15,16 34:6 35:4 41:3 42:14 178:18 180:20 181:7,8,16 182:4 196:21 228:5,6,11 assert [1] 216:24 assertion [1] 79:23 assess [4] 11:25 67:10 188:20 256:12 assessed [4] 77:18 84:22 179:25 201:10 assesses [1] 68:8 assessing [3] 74:5 115:21 153:21 assessment [11] 25:22 39:10 55:3 64:2 87:13 92:3 166:3 188:16 199:1 211:23 322:2 assign [1] 264:5 assigned [1] 358:20 assist [8] 95:7 182:22 205:20 214:4 252:19 260:6 263:15 321:11 assistance [6] 12:19 221:8 235:7 280:12,14 280:23 assistant [3] 314:22 349:12 375:18 assistants [4] 314:18 315:6 321:8,11 association [6] 1:14 13:6 22:8 103:1 350:23 351:18</p>	<p>assume [11] 70:11 73:4 82:1 113:10 123:18 162:25 203:12 204:24 329:7,14 330:3 assumed [1] 201:6 assuming [8] 51:14 72:9 89:1 97:10 109:15 125:1 137:15 272:11 assumption [8] 79:6 200:6,14,16 273:22,25 314:5,7 assurance [12] 21:12 54:8 89:23 209:6 211:10 211:14 249:1 327:25 353:1,2,12 357:17 assure [1] 255:16 attach [2] 233:23 235:14 attached [6] 105:17 106:23 235:21 266:21 328:12,18 attaches [1] 162:22 attachment [1] 235:24 attempting [2] 204:1 325:1 attendance [4] 35:18 36:20 38:19 270:17 attending [2] 35:9,11 attention [19] 14:9 15:17 17:10,14,16,17 31:24 59:20 123:17 124:10,16 125:19 127:12 130:5 133:7 134:5 296:3,6 367:21 audible [1] 243:10 auditing [2] 353:2,3 audits [2] 350:14 353:11 August [7] 69:24 72:24 73:7,11 75:21 77:1 248:5 authorities [4] 1:17 311:8 315:16,21 authority [3] 1:11 309:13 325:16 autoclave [1] 230:22 automated [5] 246:15 247:3,10,14 248:15 automatic [1] 332:23 automatically [1] 7:21 automation [2] 246:21 247:7 automobile [1] 353:7 autostainer [2] 71:19 298:8 avail [1] 23:13 available [9] 24:21 57:21 57:22 90:2 212:3,7,8,18 300:17 average [3] 56:24 297:10 319:19 aware [30] 15:23 16:15 32:5 58:1 59:4 72:24 95:6 101:10 104:22 107:6 110:4 123:24 124:8 127:10 128:6 136:16 148:14,22 149:4 173:7 194:21 212:10 296:21</p>	<p>299:11 332:1 333:16 341:4,8 342:23 343:1 away [1] 76:7 awful [2] 104:12 245:17</p> <hr/> <p style="text-align: center;">-B-</p> <p>Bachelor [1] 348:19 backflow [1] 368:21 background [14] 46:3 47:12 104:12 252:20,20 256:12,15,23 257:1,23 262:16 348:16 355:23 356:7 Banerjee [2] 43:1 317:8 Banff [1] 19:18 Barry [8] 93:9 95:1,7 152:19 246:14 285:15,23 292:22 base [3] 15:22 209:7 368:13 based [18] 78:1 97:23 101:6 110:7 114:17 131:24,24 136:12 137:7 141:11 147:15 168:17 177:5 183:13 297:19 299:17 336:15 353:5 basic [20] 10:9 12:12,14 13:12,19 16:7 23:10,14 24:10,18 29:5 42:8 63:2 71:14 95:3 160:20 228:19 236:25 353:1,19 basics [1] 228:21 basis [19] 24:22 56:13 79:25 110:14 139:23 158:1 162:14,14 171:24 200:20 207:7,11 208:20 208:23,24 221:9 253:11 351:22 367:4 batch [4] 249:17 250:1,9 251:2 bath [3] 230:24,24 231:1 beat [1] 326:11 became [26] 10:12,17 11:23 48:2 51:10 194:20 223:4 257:17,20 319:12 349:2,4,7,11 361:9 370:11,14,24 371:3,9,11 372:10 373:5,12 374:2 375:17 become [3] 190:15 287:24 372:1 becomes [1] 147:13 becoming [1] 375:5 begin [1] 348:15 beginning [10] 16:23 78:4,21,23 79:22 135:3 150:22 221:19 319:11 358:6 begins [1] 339:7 behalf [2] 282:13 304:14 behind [2] 9:18 279:20 belief [2] 77:16 340:13 believes [1] 324:13 below [2] 87:1 168:17 bench [15] 12:6,17 16:24</p>	<p>23:21 46:13,15 186:14 200:4 233:24 235:14 240:17 259:5 260:8,14 323:14 beneficial [1] 365:21 benefit [6] 17:23 96:1,4 181:23 182:17 313:4 Bernard [1] 1:6 best [25] 27:13 29:17 92:12 93:14,21 94:2 107:10,12 138:4,11,16 140:14 157:11 182:2 184:3,19 228:13 231:7 279:7 335:2,3 337:6 342:5,10 377:9 better [5] 177:19 228:10 312:14 360:9 365:16 between [18] 35:17,23 69:25 73:10,23 76:9 77:12 136:18 146:17 188:11 189:9 195:1 265:23 282:14 293:11 294:7 302:9 313:3 beyond [1] 366:24 big [7] 21:16 168:6 170:22 197:3 269:21 357:5 366:11 bigger [1] 354:23 biggest [2] 58:15 316:3 bind [1] 225:6 bio [2] 7:1,1 biochemical [11] 33:15 34:6 35:4 41:2 42:14 67:24 179:16 181:6 228:5 228:10 314:3 biochemistry [18] 9:8 33:15 67:25 178:19 179:21 181:3,9 194:9 195:2 196:2,20 199:21 200:12 315:14,23,24 317:24 321:25 biomedical [1] 6:16 biopsy [1] 318:8 biostats [1] 360:8 bit [12] 22:11,12 26:24 169:7 211:11 218:21 222:7,25 228:8 231:15 302:3 355:16 bits [1] 151:18 Blair [1] 1:16 block [7] 47:19 125:1 158:19,19 197:10 307:10 318:4 blocked [1] 329:6 blocks [13] 47:14,15,25 48:4,5,15 64:20 95:3 196:23 197:7,18 213:23 213:24 blood [3] 257:6,7 279:18 BN [2] 350:19 355:23 board [2] 19:11,21 boards [1] 364:8 boat [1] 120:12 Bob [1] 55:17 body [1] 105:17</p>	<p>boil [5] 227:7 228:12 239:20,25 240:9 boiled [2] 232:7 241:7 boiling [3] 227:5,12 240:4 bone [1] 353:24 Bonnell [1] 70:6 book [1] 50:13 borne [1] 99:23 bottle [1] 343:21 bottom [9] 170:20 192:20 248:24 259:14,16 287:23 288:4,15 299:6 brain [1] 180:4 Brazil [1] 1:8 break [11] 133:14,17,19 133:20 134:12 136:15,15 224:8,8 291:4,7 breakdown [2] 86:11 88:4 breaking [1] 160:9 breast [12] 1:12 84:17 164:5 178:9 181:4 246:5 297:7 301:6,12 317:13 335:12 337:2 briefly [2] 176:2 308:21 bring [24] 14:9,13,18 30:1 57:22 59:19 60:6 64:2 84:2 86:5 105:7 123:17 124:9 130:4,13 130:16 131:1 132:12 152:7 191:1 297:17 304:19 319:24 367:21 broad [1] 368:13 broader [4] 27:12 30:8 113:10 139:19 broken [9] 87:6 121:13 121:24 122:21,24 158:5 158:9,12 357:22 Brook [2] 47:17 119:2 brought [17] 12:2 15:17 17:13,15,16 27:23 28:4 28:10 29:16 51:11 124:16 125:18 127:12 133:7 134:5 227:24 338:13 brown [1] 225:7 Browne [168] 1:9 2:3 4:2 4:3,4,5,10,11,19 5:4,12 6:4,12,17,22 7:5,11 8:7 8:12,23 9:14,19 10:5,11 10:16,21 11:4,11,17,22 12:20,25 13:15,22 14:2 14:16,22 15:1,8,15,25 16:4 17:6,19 18:15,20 20:1,10,19 21:3,10,20 22:5,10,18,24 23:24 24:11,20 25:1,14 26:7 26:25 27:6,10,21 29:14 29:24 30:15,23 31:5 32:15,24 33:11,17 34:1 34:8,15,25 35:14 36:2,6 36:13,24 37:13,17 38:2 38:6,11,15,21 39:3,22 40:17,22 41:6,12 42:4 42:15 43:5,10,16,20 44:2 44:14,24 45:6,18,22 46:19 47:22 48:8,13,18</p>
--	---	---	---	---

<p>48:22 49:13,21 50:4,21 51:4,16 52:3,8,19 53:11 53:16,23 54:16,22 55:4 55:8 56:4 57:2,20 58:17 58:25 59:11,17,24 60:4 60:15 61:9 62:1,8,15 63:5,20 64:5 65:3,12,17 65:22 66:10 67:3,17 68:4 68:13,25 69:10,18,22 70:4,12,23 71:20,25 72:5 72:6</p> <p>bubble [1] 240:9 bucks [1] 203:16 budget [10] 199:24,25 290:18 295:13 313:11,20 316:15 318:17 319:2,4 budgetary [1] 287:14 budgeted [1] 288:22 budgeting [2] 214:7 288:21 budgets [1] 334:24 buffer [1] 227:11 buffered [3] 49:19 50:20 257:9 build [1] 353:11 building [1] 58:13 bulk [2] 49:4 98:12 bullet [1] 86:24 burden [1] 325:22 Bussey [2] 260:12 261:22 Butler [10] 12:1 23:1 64:7 154:12 186:19 208:6 260:3,4 277:24 341:19 buy [2] 199:6,7 buzzer [1] 243:2</p>	<p>CANCELLED [1] 3:29 cancer [10] 1:12,15 72:21 84:17 178:9,21 246:6 301:12 335:12 337:2 cancers [2] 297:7 301:6 candidate [1] 78:16 cannot [1] 279:19 canvas [1] 8:16 canvassed [1] 8:25 CAP [2] 68:1 69:21 capacity [1] 372:5 capture [1] 34:21 Carbonear [3] 46:16 121:8 332:7 care [26] 23:12 46:7 58:23 76:11 288:15 321:9 334:9,12,17,21,22 336:21 337:1 348:25 349:3,5 354:17 356:10,12,19,23 365:10 368:10 369:9,15 369:24 Carolyn [2] 77:15 79:19 carried [1] 343:3 carry [3] 16:21 234:2 345:5 Carter [10] 70:1,24 85:12 87:15 88:2,9,24 246:4,4,20 Carter's [4] 87:8 90:13 92:3 97:22 case [14] 7:16 86:10 100:22 125:25 137:25 181:25 183:14,19 204:6 254:25 264:6 303:20 333:12 341:25 cases [25] 39:12 87:16 88:24 89:12 98:4,8 115:19 147:23 156:6 166:4 249:22 250:1 263:20 269:18 275:11 283:10 304:25 306:4,18 319:21 331:10,17,19,25 333:6 cassette [1] 16:14 cast [1] 140:10 catch [1] 276:19 categories [6] 115:25 116:3 121:7,16 164:11 266:3 categorize [3] 136:5 168:19 264:24 categorized [1] 166:16 category [4] 83:18 165:2 305:22 333:13 caused [2] 99:17 367:20 causes [2] 104:22 105:1 causing [1] 368:22 cc'd [5] 59:13,15 285:19 285:21 286:12 cells [2] 42:3 264:6 celsius [1] 8:2 centigrade [1] 239:20 central [2] 1:16 370:9 centralization [3] 51:7</p>	<p>51:14,19 centralized [1] 369:7 centrally [1] 369:19 centre [6] 35:24 46:22 64:24 334:9,15,15 centres [1] 323:21 centrifuge [1] 257:7 CEO [3] 55:17 203:20 325:16 certain [10] 7:20 9:12 56:14 183:16 227:12 236:10 260:15 269:11 311:10 368:2 certainly [32] 6:7 12:9 15:23 19:24 32:23 64:3 74:11,13 80:6 103:22 113:21 118:17 119:20 120:5 127:10 129:13,18 137:10 189:19 194:6,10 219:8 226:7 245:12 253:5 262:3 274:15 281:20 302:25 308:6 310:5 321:23 Certificate [2] 2:10 377:1 certification [2] 4:24 9:1 certify [1] 377:2 cetera [1] 73:17 chain [1] 19:13 challenge [2] 365:13 366:11 challenged [1] 71:13 challenging [1] 71:10 chance [2] 242:10 312:18 change [22] 74:15 78:1 87:3 111:24 112:1,22 113:12 114:12 136:7 137:22 138:7 139:8 140:7 142:7,9 143:4 162:1 169:4 173:21 307:24 355:8 369:1 changed [19] 74:7,18 77:12,24 80:21 109:13 113:18 114:15 118:20 138:22 218:1 333:14 341:6 371:3,11 372:14 375:15,20 376:1 changes [1] 88:3 changing [1] 30:11 charge [4] 47:10 193:2 207:8 209:3 chart [2] 105:20 353:25 charts [1] 353:24 Chaytor [122] 1:7 2:7,9 4:21 22:12 31:7 34:18 42:19 51:6 58:4 60:7 177:20 223:11 228:21 286:20 290:25 299:25 302:24 338:3,4,5,23 339:5,13,17 340:4,14,20 340:25 341:10,17,23 342:6,11,17,22 343:10 343:15,22 344:1,7,12,25 345:2,9,10,13,14,18 346:1,5,9 347:9 348:13 349:14,21 350:6,18 351:4</p>	<p>351:10,15,19 352:3,8,16 352:20 354:10,15 355:13 355:21 356:3,11,17 357:14 358:1,8,13,17,24 359:5,10,17,23 360:2,12 360:20,25 361:6,10 362:6 362:10,16,21 363:11,16 364:1,25 365:4 366:2 367:2,7,18 368:15 369:4 369:13 370:10,17,23 371:15,19 372:3,8,19,24 373:4 374:1,9,19,23 375:2,9,22 Chaytor's [2] 4:13 177:24 check [3] 234:25 256:17 353:14 checked [1] 306:23 checking [1] 8:16 chemistry [7] 34:7 46:15 68:24 180:21 200:10 318:7 319:3 Chesley [3] 1:12 2:5 177:16 chief [29] 14:21,23 15:11 15:12 16:8 17:16 18:13 18:14 35:15 59:22 94:16 130:14 185:25 186:1 216:12,21 217:9,11,20 219:20,25 220:4,6,21 221:13 253:15 287:9 317:25 363:23 Chittal [11] 10:25 11:12 12:18 218:20,24 219:1,5 219:10 220:4,6 224:5 chosen [1] 325:17 chunk [1] 314:20 circumstances [1] 327:7 city [9] 48:3 52:2,15,17 54:15 56:1,12,18 58:23 city-wide [1] 29:2 Clare's [43] 15:23,24 16:8,9,19,21 17:17 18:5 18:10 28:3,17,21 29:9 35:23 45:10,12,24 46:9 46:13,14 47:23,24 48:3 53:8,9 54:3,4,14 55:12 55:20 56:22 58:8,9,13 119:2 121:10 278:4 290:11 369:20,23 370:4 370:9 Clareville [14] 121:9 269:2,10 270:1,21 271:4 272:14,16,21 273:14,23 274:23 275:1,5 clarification [1] 51:18 clarified [2] 25:4 42:18 clarify [1] 4:12 class [6] 1:13 75:16 102:20 111:7 178:8,9 classified [3] 84:25 161:25 268:1 clear [3] 60:16 90:4 299:10 clinical [33] 15:12 18:14 59:22 68:9 94:15,16 128:15,16 130:14 156:18</p>	<p>185:25 188:12,15,25 189:9,20 193:1 201:2,21 204:9 219:12 247:20 262:4 266:8 280:13 287:8 299:4 311:4 317:10,24 330:10 336:15 363:23 clinically [4] 264:13 265:4 282:11 299:9 clock [2] 242:25 243:6 clone [1] 259:11 clones [1] 260:15 close [4] 54:5 195:16 207:10 329:24 closed [3] 18:9 53:3,4 closely [2] 16:18 207:7 closer [1] 283:15 closing [5] 52:12,13 65:25 327:14 337:18 club [1] 63:12 CMLS [1] 18:22 co-authors [1] 313:5 Co-counsel [2] 1:6,7 co-ordinating [1] 362:1 co-workers [1] 335:5 coagulation [1] 67:25 code [1] 366:19 coded [1] 30:20 Coffey [5] 1:6 177:24 178:2 292:1 313:2 cognizant [1] 129:21 coincidentally [2] 370:14 371:2 colleague [1] 349:25 colleagues [6] 19:4,4 20:21 63:13 66:2 103:2 collect [3] 73:14 74:3 257:5 collecting [1] 73:25 collection [2] 109:9 279:18 column [2] 164:12 265:5 columns [1] 117:8 combination [10] 13:8 13:10 19:7 30:4 31:20 31:21,25 34:10 154:20 154:23 combined [1] 188:11 comfort [1] 345:8 comfortable [2] 365:1 365:5 coming [10] 8:13 14:8 18:16 57:3 85:2 107:22 110:18 118:10 194:16,18 command [1] 59:18 commenced [1] 184:12 commencing [1] 228:16 comment [11] 25:15 32:1 34:9 128:19 176:13 177:23 309:4 320:20 322:24 327:6,8 comments [1] 31:11 commercial [1] 49:1 Commission [16] 1:1,6</p>	
<p style="text-align: center;">-C-</p> <p>c [8] 207:17,17 213:25,25 230:23 231:1 347:4,4 C-0264 [2] 3:26 348:11 C-0265 [3] 3:26 347:5 348:11 C-0273 [3] 3:27 347:5 348:12 C-0274 [3] 3:27 347:5 348:12 C.V [2] 375:3,24 C.V. [1] 374:24 calculated [1] 298:17 calculating [1] 269:1 calculation [3] 265:15 298:5 299:12 calculations [2] 273:12 298:4 calibration [5] 5:19 6:7 6:8,9 8:4 Cameron [3] 1:3 337:19 377:6 Canada [1] 337:12 Canadian [6] 1:15 19:10 72:21 337:5 350:23 351:18 cancel [1] 368:24</p>					

<p>1:7 4:8 57:7 191:15 219:4 230:15 245:13 253:22 326:20 334:4 337:10 345:21 377:4,7 Commissioner [77] 1:3 4:1 16:25 61:14 70:16 72:4,7,8,12,13 83:3,9 105:9 133:12,18,21 177:14,18,22 178:4 191:10 206:20,24 207:3 224:6,13,18,19,22,25 230:12 255:22 256:3 267:22 270:24 271:9,13 271:18 290:24 291:3,8 292:15 301:19 320:7 324:11,19 325:2,11,24 326:6,15,21 327:3,15,19 327:20 328:2 338:1,2 340:6 342:13 344:13,14 344:19,24 345:4,12,15 346:12 347:11 348:14 373:10,16,24 375:24 376:3 377:7 commit [1] 288:17 commitment [1] 295:15 committed [4] 289:12 289:20 291:18 296:9 committee [3] 20:15 37:2 195:9 common [1] 128:20 commun [1] 65:23 communicated [3] 17:25 47:1 209:9 communicating [3] 64:13,23 66:15 communication [5] 15:3 64:21 293:11 294:6 294:13 communications [4] 19:17 70:7 152:22 153:22 community [6] 86:8 320:19 322:3 351:1 359:22,24 companies [1] 12:16 company [1] 47:6 comparable [1] 271:10 compare [10] 89:20 94:18 99:14 116:3 160:8 272:12,15 273:5,10 274:5 compared [1] 94:11 comparing [1] 117:17 comparison [2] 90:14 157:14 competency [1] 5:9 compile [2] 95:19 116:8 compiled [6] 93:1,7 94:11 96:18 100:4 142:22 compiling [1] 95:12 complaint [1] 362:4 complaints [1] 364:11 complete [7] 157:21 158:18,20,21 300:5 304:19 345:20 completed [6] 157:9 161:2 272:22 273:4 304:18,22</p>	<p>Complex [1] 9:25 complicates [1] 26:23 compliments [1] 288:10 component [3] 30:7 57:17,19 components [1] 351:24 composed [1] 192:9 comprehensive [1] 352:1 computer [20] 23:6,10 23:14,17 24:2,4,7,10,14 24:18 29:3 153:16 154:14 192:9 300:18 304:13,17 305:1,7 307:8 computers [2] 23:2,5 concentrated [2] 50:1 50:15 concept [2] 79:17 353:10 concern [25] 54:2 58:15 76:13 85:3 97:6 99:22 100:19 103:20 128:24 129:9,22 130:1 147:11 147:13,17 148:2 149:10 149:12,24 150:2,12,12 150:24 193:7 367:20 concerned [10] 58:7 70:25 71:5 100:1,2,15 103:23 129:15 170:17 320:5 concerning [1] 267:19 concerns [11] 54:7 55:18 55:21,25 56:17 57:3 292:14,19 293:13 295:7 295:9 conclusion [1] 140:11 concrete [1] 369:5 conducted [6] 57:6 178:18 179:15 248:25 249:11 275:19 conducting [1] 148:23 conference [1] 22:4 confidence [1] 187:2 confident [1] 78:22 confirm [1] 82:15 confirmed [12] 82:25 83:25 85:15 86:3,25 87:7 87:17 89:7 92:8 98:9 163:13 173:22 confirming [1] 89:14 conforming [1] 271:24 Congress [4] 13:7,12,25 22:3 conjunction [2] 156:1 296:20 conscious [1] 320:8 consensus [1] 37:4 consent [2] 363:5,7 consequences [1] 193:1 consequently [1] 16:15 consider [12] 140:24 141:15 142:7 143:2,5,8 143:23 144:2,11 145:7 145:10 168:13 considered [10] 132:18</p>	<p>133:2 137:13,19 177:7 266:2 318:12 330:10 331:4 332:11 considering [1] 138:19 consistent [3] 110:6 132:17 340:7 consistently [1] 340:10 consolidate [2] 52:14 57:18 consolidation [6] 28:15 28:16 30:5 53:10 57:14 58:6 constituted [1] 265:24 construction [1] 58:2 consult [2] 29:17 56:7 consultant [2] 349:12 375:18 consulted [2] 27:13 29:20 consults [1] 85:23 consumed [1] 31:17 consumer [2] 352:1 357:23 contact [2] 214:25 362:15 contacted [1] 7:6 contacting [1] 153:23 contained [4] 105:6 117:1,12 297:20 contains [2] 106:18 117:7 contemplated [1] 73:19 content [4] 25:6,16 86:18 267:19 CONTENTS [1] 2:1 continue [2] 278:2 336:22 continued [4] 29:10 349:6 371:20,22 continues [2] 324:9 336:3 continuing [1] 350:20 continuous [4] 247:25 353:9,13,15 continuously [1] 189:12 contradicts [1] 103:18 contrast [1] 180:18 contributed [1] 366:5 contribution [3] 77:14 79:18 344:21 control [52] 21:11 61:5 191:2 205:8 209:4,12,15 209:17,25 210:1,3,5,8 210:10,24 211:1,5 217:15 217:24 249:23,23 250:8 250:15,17 251:3,12,18 251:24 252:13,15,17,18 252:19 257:10,22 270:22 271:5,10,15 272:2 275:9 275:10,14 276:19,24 281:23 320:8 322:17 357:17 371:8,14 372:1 controlled [1] 241:1 controls [53] 209:19,21</p>	<p>210:4,15 234:1 235:16 248:25 249:11,15,20 250:2,2,4,21 251:4 253:10,13,19 254:1,12 254:16,22 255:1,8,10,15 256:8,11,16,18,25 257:3 257:17 258:3,6,13,15,18 259:19 260:18 261:3,5,7 262:7,12,18 274:11,13 274:14,25 275:19 277:2 281:16 controversial [2] 276:21 277:5 convenient [1] 224:7 conversation [1] 193:6 conversion [17] 112:6 114:10 126:4,5 131:21 131:24 132:2 136:23 137:4 140:25 141:16 142:8 143:6,21 146:22 175:4,6 conversions [34] 91:25 92:2 93:2 98:18 100:5 101:9 103:17 105:4 111:23 116:9,24 128:25 134:3,3,9 135:13,20,21 135:25 137:7 138:9 139:2 140:10 147:7 149:7 160:7 161:8,9,9,13,15,16 173:22 174:1 converted [8] 96:13 97:25 99:13 100:24 108:12 124:12 173:14 175:22 converter [11] 98:9 107:21 108:2,11 132:6 132:18 133:3 136:4,6 137:13 142:1 converters [13] 84:25 94:12 95:10,13,19 107:5 110:5 112:11 131:17 148:20 151:21 161:24 328:22 converting [7] 101:5 133:9 135:10 141:24 143:3 145:9 146:11 converts [5] 115:7 134:22,25 135:4 142:15 Cook [44] 54:2,7,23 55:9 55:16,18 56:16 58:5,7 59:22 81:16 155:18 156:20 159:2 274:22 282:1,2,16,16,24 283:2 283:7 291:13 292:9,18 292:25 293:1,12,16,24 294:7,15 295:20 296:12 296:20 307:13 313:2,5 316:15 319:24 320:17,22 320:24 321:22 Cook's [7] 54:11 55:25 57:3 154:6 291:11,20 313:1 cooker [4] 230:21 231:23 231:25 232:13 cookers [1] 229:2 cool [1] 240:10 coordinator [1] 348:25 copied [4] 59:7,9 157:3 176:7</p>	<p>copies [1] 287:8 coplin [1] 227:18 copy [13] 12:13 66:6 95:20 157:3 233:23 235:1 235:14 259:4,13 260:8 267:2 283:3 285:6 copyright [1] 256:6 core [1] 317:1 Corner [2] 47:17 119:2 Corning [2] 231:8,9 Corp [1] 356:19 Corporation [12] 23:12 46:7 76:12 256:6 349:3 349:5 356:10,12,23 365:10 369:16,25 correct [30] 79:10,25 80:1 93:24 114:17 121:22 162:25 178:21,23 179:19 180:5,24 184:4 185:2 189:6 205:13 218:12 221:7 225:10 234:16 252:11 266:23 275:22 283:7 314:5 332:12 340:3 356:14 370:20 377:3 corrected [1] 40:1 correctly [10] 27:3 34:22 78:3,21,23 79:22 185:11 209:5 235:9 311:22 correlate [1] 89:14 correlation [3] 37:3 41:2 42:13 correspondence [2] 351:11 355:24 corridor [1] 286:23 cost [9] 199:18 200:18 313:3,23 319:4,15,16,19 334:5 counsel [4] 178:8 337:19 362:5,14 count [2] 179:4 265:6 country [7] 5:1 20:24 21:17 56:10 103:2 321:10 321:14 couple [11] 31:11 110:3 121:16,20 132:14 162:18 165:13 227:3,3,8 237:17 course [17] 4:13 24:7 181:11 184:6 185:4 243:23 244:9 351:2,5,6 351:12,16,20 352:1 353:4 354:5 355:24 courses [7] 23:4 24:4 350:20,25 354:8 356:4,5 cover [2] 13:9 199:25 covered [4] 9:5 79:17 351:22,24 CQI [2] 351:23 353:9 create [2] 47:9 314:17 created [5] 47:20,21 154:15 156:24 215:10 creating [1] 179:1 credible [1] 258:17 credit [1] 108:9 criteria [5] 37:8 39:14 329:16 330:24 331:20</p>
---	---	---	--	--

<p>critical [8] 33:4 126:13 277:10,17 279:5 290:24 334:16 368:10</p> <p>Crosbie [441] 1:12 2:5 177:15,16,17 178:1,6,24 179:10,14,20 180:8,12 180:16 181:10,15,21 182:3,7,11,19 183:6,10 183:20,24 184:5,10,20 185:3,12,18,23 186:5,11 186:18,25 187:6,25 188:5 188:24 189:7,15,23 190:5 190:17,25 191:20,24 192:4,11,17 193:11,22 194:1,12,19,25 195:7,15 195:22 196:7,16 197:2 197:11,16,21 198:2,13 198:17 200:5,13 201:5 201:18 202:10,17,21 203:3,15,25 204:13 205:4 205:10,14 206:9,13,17 206:22 207:1,5,15,24 208:11,18,25 209:24 210:6,13,20,25 211:4,8 211:17 212:2,12,16,22 213:5,9,14 214:6,11,16 215:3,7,13,18,23 216:2 216:10,17,22 217:3,10 217:19 218:4,10,15,23 219:3,18,23 220:3,8,9 220:14,19,24 221:6,12 221:17,22 222:1,6,10,15 222:20 223:1,10,15 224:7 224:9,15,23,24 225:11 225:19 226:1,6,17,22 227:2,16,23 228:20 229:8 229:14,18 230:2,8,18 231:10,14,19 232:1,10 232:15 233:2,8,14,18 234:6,10,17,23 235:12 235:22 236:9,15,20 237:5 237:12,18 238:1,8,12 239:1,10,16 240:2,14,25 241:5,11,15,22 242:2,13 242:17 243:5,9,14,18,22 244:6,21,25 245:7,14,22 246:2,9,22 247:12,19 248:12,18 249:6,10,14 250:6,12,16,20,25 251:8 251:15 252:7,12,22 253:4 253:9,21 254:5,10,17,20 254:24 255:4,11,19,25 256:5 257:13 258:1,8,16 258:22 259:12,25 260:5 260:13,24 261:8,14,23 262:6,11,17,23 263:4,14 263:24 264:11,17 265:1 265:13 266:16 267:1,12 267:24 268:5,16,24 269:7 269:20 270:2,9,14,20 271:1,2,11,16,21 272:7 272:17,23 273:8 274:7 274:19 275:4,17,23 276:3 276:11,17,25 277:8,15 277:21 278:10,17,22 279:2,9,13,24 280:5,18 280:25 281:11,25 282:7 283:5,11,17,25 284:6,23 285:3,20,25 286:7,14 287:13,18 288:3,12 289:1 289:6,10,17 290:23 291:5 291:9,10 292:4,8 293:4 293:10 294:5,12,16,21</p>	<p>294:25 295:5,12,19 296:1 296:11,23 297:16 298:16 298:20,25 299:8,17,22 300:9,21 301:8,17,23 302:5,11,17,22 303:6,12 303:24 304:3,7 305:2,9 305:13,21 306:4,10,15 306:19 307:1,9,15 308:1 308:8,19 309:5,12,18,22 310:8,15,19 311:11,16 312:1,9,13,23 313:10,19 314:1,11 315:1,8 316:12 317:17 318:10 319:5,8 319:23 320:2,9,10,16 321:18 322:5,23 323:3 323:12,24 324:5,25 325:12 326:1,10,24 327:1 327:16 338:9,25</p> <p>cross [1] 225:4</p> <p>crude [1] 231:15</p> <p>cruder [1] 233:15</p> <p>CSLT [1] 19:9</p> <p>CSMLS [1] 19:9</p> <p>cultural [1] 54:2</p> <p>current [6] 27:23 28:20 199:12 247:2 290:5 302:12</p> <p>curve [1] 194:13</p> <p>cut [16] 35:20,22 39:14 40:6 41:1,22 47:16,24 47:24 48:5,15 54:19 142:7 143:4 299:6,20</p> <p>cutoff [1] 332:10</p> <p>cutting [2] 213:24 334:6</p> <p>cycle [1] 353:14</p> <p>cytometry [1] 67:24</p> <hr/> <p style="text-align: center;">-D-</p> <hr/> <p>Dabbs [2] 309:8 312:2</p> <p>daily [11] 190:15 207:7 207:11 208:20,23 209:4 210:3,7 214:25 219:5 223:22</p> <p>DAKO [38] 23:6 24:3,14 24:23 25:2 33:8 64:8 65:2 66:13 71:7,18 162:24 167:3 169:9,12 174:16 229:5 230:25 232:7 233:4,5,24 235:15 237:24 238:3 255:6 256:6 259:6 260:9,17 263:17 265:6,9 283:20 297:8 298:7 319:16 338:20</p> <p>Dan [2] 2:6 328:4</p> <p>dangerous [3] 177:25 327:22 365:6</p> <p>Daniel [1] 1:10</p> <p>data [18] 26:20 31:1 101:8,13 105:4 117:12 133:25 151:19 158:22 161:3 163:17 175:14 176:13 273:10 282:10 284:16 297:5 304:12</p> <p>database [7] 27:9 90:24 287:13,18 288:3,12 289:1 289:6,10,17 290:23 291:5 291:9,10 292:4,8 293:4 293:10 294:5,12,16,21</p>	<p>343:1,2,6</p> <p>dated [3] 84:14 301:2 377:11</p> <p>Dawe [2] 349:25 350:1</p> <p>day-long [1] 357:20</p> <p>day-to-day [2] 139:22 360:22</p> <p>days [7] 19:16 24:18 279:21 313:7 333:23 334:3 344:16</p> <p>DC [1] 323:21</p> <p>deal [3] 365:13,24 368:14</p> <p>dealing [8] 5:21 19:4,17 19:21 20:21 53:24 113:1 214:12</p> <p>dealt [2] 153:19 197:17</p> <p>Deane's [1] 343:3</p> <p>dear [2] 192:18 335:10</p> <p>debate [1] 284:18</p> <p>Deborah [1] 176:6</p> <p>deceased [11] 109:12,16 109:21,24 111:3,13,17 113:18 116:9 149:10 161:9</p> <p>December [1] 39:4</p> <p>decide [5] 28:13 42:2 100:14 101:11 326:16</p> <p>decided [2] 83:14 199:3</p> <p>decision [18] 29:25 30:8 30:13 52:14 57:13 160:25 178:13 253:13,17,18,23 253:24 254:1,2,7,9,12 335:13</p> <p>decisions [1] 159:13</p> <p>dedicate [1] 206:2</p> <p>dedicated [10] 43:24,25 287:22 290:3 295:10 314:24 316:25 317:15 321:15 337:15</p> <p>deemed [3] 78:15 82:11 96:9</p> <p>defined [4] 107:21 313:11 317:18 318:13</p> <p>Definitely [1] 281:17</p> <p>definition [8] 21:1 136:4 136:23 161:16 185:8 207:22 266:8 284:21</p> <p>definitively [1] 237:16</p> <p>degree [7] 55:11 87:2 166:4 240:12 266:13 359:14 360:11</p> <p>degrees [2] 231:1 241:19</p> <p>deletion [1] 190:2</p> <p>delicacy [6] 192:25 193:8 194:4 244:11 245:18 324:2</p> <p>delicate [1] 244:22</p> <p>delve [1] 99:17</p> <p>Demmings [1] 353:6</p> <p>demographic [1] 158:2</p> <p>Denic [14] 81:15 93:14 93:17 94:16 95:1,6,9,18 96:18 105:15 106:21 130:13 148:14,22</p>	<p>department [23] 6:16 86:7 152:21,22 153:22 320:25 321:6 348:23 349:8 362:25 366:16 369:19 370:2 371:2,5,11 372:16 373:23 375:14,16 375:20,21 376:1</p> <p>depend [1] 367:24</p> <p>depended [1] 250:2</p> <p>depending [4] 83:11 249:24 282:10 363:20</p> <p>depose [2] 325:14,15</p> <p>deprived [2] 185:6 308:3</p> <p>derived [1] 111:2</p> <p>describe [5] 179:3 195:23 196:8 198:3 231:22</p> <p>described [5] 216:4 239:3 288:19 305:25 309:25</p> <p>describes [1] 278:13</p> <p>describing [4] 228:15 228:17 277:9,10</p> <p>description [2] 198:14 226:9</p> <p>deserved [1] 296:2</p> <p>design [1] 153:2</p> <p>designated [2] 206:2 214:21</p> <p>designation [1] 230:9</p> <p>designed [1] 27:22</p> <p>desirable [1] 52:24</p> <p>despite [1] 42:7</p> <p>detail [2] 21:9 237:2</p> <p>detailed [4] 57:25 69:15 198:12,14</p> <p>detected [1] 263:13</p> <p>detection [7] 31:19,24 32:7,19 33:21 34:10 178:20</p> <p>determination [2] 81:1 266:4</p> <p>determine [5] 37:9 74:6 138:8 269:25 326:22</p> <p>determined [5] 81:4 112:9 142:5 248:24 327:4</p> <p>develop [1] 350:14</p> <p>developed [4] 297:12 350:15 353:8 375:17</p> <p>developing [5] 76:10 195:17,21 357:2,6</p> <p>development [2] 190:1 196:1</p> <p>device [1] 368:20</p> <p>dewax [1] 238:22</p> <p>DI [2] 58:11 368:7</p> <p>diagnosed [1] 84:17</p> <p>diagnoses [1] 180:2</p> <p>diagnosis [8] 26:3,19 181:12 182:22 184:14,25 288:14 334:20</p> <p>diagnostic [3] 182:21 184:15 368:8</p> <p>diagram [1] 353:25</p>	<p>dibasic [1] 50:10</p> <p>dictionaries [3] 28:3,14 30:19</p> <p>dictionary [1] 29:2</p> <p>differ [1] 5:7</p> <p>difference [11] 33:16 146:17 168:6 274:9 286:16 316:13 354:20,22 354:24,25 361:12</p> <p>differences [1] 28:14</p> <p>different [47] 25:17,23 25:24 28:1,2 30:12 45:9 49:25 67:2 79:13 92:15 112:24 113:8 119:4 126:8 135:24 174:10 178:14 184:7 203:11 242:21,22 242:22 251:21 258:25,25 259:1 265:2,20 268:25 269:4 284:7 289:21 299:20 341:5,5 342:18 352:21 353:21 354:17 355:9 358:19,21 363:5 364:9,17 375:15</p> <p>differently [2] 127:6 251:19</p> <p>difficult [3] 26:9 334:10 369:2</p> <p>difficulties [1] 25:5</p> <p>digestion [2] 226:13 245:6</p> <p>Dillon [1] 176:7</p> <p>dilution [10] 199:4 340:17 341:4,13,15 342:1 342:18 343:11,14,20</p> <p>dilutions [1] 341:6</p> <p>diploma [1] 4:23</p> <p>direct [2] 59:25 280:16</p> <p>directed [1] 46:21</p> <p>direction [2] 253:25 256:7</p> <p>directly [7] 15:10 60:3 60:14 213:13 268:21 270:13 282:24</p> <p>director [45] 14:10,14 15:18 62:7 66:6 67:15 76:20 90:9 91:7 94:21 96:1 102:2 112:25 114:23 115:9 129:25 138:20 145:4 159:10 186:1 189:24 199:9 215:17,19 216:4 221:1 248:7 253:16 283:18 288:25 317:25 349:7,12 359:13 370:24 371:3,7 372:2,5,23,25 373:12 375:6,7,19</p> <p>directors [3] 19:12 64:14 66:9</p> <p>disagree [3] 194:2 281:17 298:14</p> <p>disagreeing [1] 282:19</p> <p>disaster [2] 288:4 312:4</p> <p>discard [2] 75:5 76:3</p> <p>discarding [1] 76:11</p> <p>disciplines [1] 13:9</p> <p>disclose [1] 102:20</p> <p>disclosure [1] 153:23</p>
--	--	--	--	---

<p>discontinued [1] 274:23 discover [2] 114:6 305:3 discovered [3] 101:3 247:2 303:16 discuss [4] 44:3,12 153:3 162:13 discussed [8] 20:23 35:19 39:11 41:7,18 42:17 53:19 289:24 discussing [2] 32:13 39:19 discussion [22] 21:16 35:12,21 36:5 37:16,21 40:25 42:6 51:9 52:11 62:16 69:24 70:15,17 71:2,9,22 74:13 85:16 195:9 254:16,21 discussions [12] 16:7 21:13 35:6,23 37:23 42:10 44:9 54:6 61:12 195:1 196:13 199:7 dish [3] 227:13,14 231:9 dispute [3] 266:5 287:2 298:10 disseminated [1] 36:9 distinguish [2] 108:20 108:22 distortion [1] 305:15 distributed [4] 17:24 39:15 40:4 154:18 divide [1] 96:25 division [15] 1:15 10:10 14:15 16:16 46:17 72:22 152:24 322:1 371:8,12 371:13,14 372:2,15 373:22 divisional [1] 10:17 divisions [2] 322:1 371:10 doctor [1] 205:16 Doctors [1] 1:9 document [36] 74:4 86:6 86:13,16 97:20 99:8 105:14 117:2 135:3,12 152:7,9,11 154:15 162:20 176:2,5,6,9 191:1 202:3 227:24 228:3 229:19,23 229:25 232:19 233:20 244:7 248:19 255:5 262:24,25 266:17 353:23 353:24 documentation [19] 57:7,8 73:14 75:5 78:7 80:7 106:13 158:18,18 201:24 202:4 237:23 261:19 296:3 317:8 322:22 336:10 342:24 343:4 documented [11] 49:8 80:10 96:6 107:7 109:23 153:16 168:18 170:24 202:8 307:8 310:7 documenting [3] 201:23 202:5,23 documents [9] 59:6 73:16 159:3 162:18 230:6 230:15 232:21 261:9</p>	<p>297:21 doesn't [18] 98:13 99:22 157:21 191:2 192:18 193:23,25 232:18 247:9 247:17 252:8 270:10 273:9 287:4,6 299:11 302:23 326:12 dollars [1] 199:19 domain [1] 273:23 Don [1] 321:3 done [93] 7:1 12:13 32:2 33:24 47:18 50:8 57:4 57:12 62:2 64:1 78:3,20 78:23 79:22 85:23 87:15 89:19,20 93:18 94:7 121:13 125:4,10 137:16 142:17 157:14 172:17 173:17 178:15 179:16,21 180:9 181:5,23 182:4,12 182:13,20,23 184:13,14 184:24 189:2,3,4 190:19 196:22,25 197:6 228:15 228:19 236:10,24 243:23 243:24 248:10 253:24 265:21 270:1,23 271:5 272:12,14,20 273:5,12 273:20 275:15 284:15 288:22 304:4,6,19,23 305:4,6 306:11,20 307:19 315:18,20 318:4,7 319:2 319:6,21 341:21 351:2 354:8 355:23 356:4 360:18 363:3 dots [1] 225:7 doubt [2] 121:20 140:11 down [35] 62:17 84:9 87:1,3,6 121:13,24 122:21,24 154:3 158:5,9 158:12 160:9 169:5 191:2 192:19 196:11 205:23 206:18,18 234:18 240:10 256:2 259:14 261:21 265:7 267:7 287:5,12,23 289:23 293:23 317:19 357:10 download [1] 366:21 downsizing [2] 334:6 334:23 dozen [1] 89:12 Dr [283] 10:25,25 11:12 11:12 12:18 17:9 18:2 18:11 25:6,11 31:9,11 31:15 32:6,13 33:14 35:2 35:13 37:2 39:10,13 40:2 40:13,20 42:12,22,25 43:1 54:1,6,11,23 55:9 55:16,17,18,25 56:16 57:3,12 58:5,7 59:1,22 60:9,16 61:2,12,19,22 62:4,17,20,22 63:6,23 64:1,15 65:21 66:5,12 66:15,19 67:4 68:16 69:25 70:24 81:15,16,16 85:12 87:8,15 88:2,9,24 90:13 92:3 93:14,17 94:15 95:1,6,9,18 96:18 97:22 105:3,15 106:21 106:21 116:23 123:23 125:14 127:8 128:13 129:25 130:4,13,16</p>	<p>131:17 132:17 134:10 135:8,17 147:2 148:14 148:22 149:4,16,25 151:13,19 154:6 155:18 156:20 159:2 185:24,25 192:8 193:5,17,19 194:8 194:8,21 195:1,8,13,16 196:8,11 197:23 198:9 198:21,24 199:14 200:3 200:17 201:1,10,15 204:16 208:12 209:2,11 209:20 212:9 213:1 214:24 215:12 216:5,11 216:12,15,20,23 217:4,5 217:6,12,23 218:5,6,18 218:19,24 219:1,5,8,9 219:10,19,24 220:4,6 221:13 223:3,12,17,18 224:5 228:3,17 244:8,17 245:1 246:4,4,20 248:7 248:8,10,20 257:3,11 266:18 267:13,20 268:7 270:10 274:22,22 275:7 275:25 278:2,12 282:1,2 282:8,15,16,24 283:2,7 283:7 286:22 287:9 289:3 289:13,18,23 290:1,6,20 291:11,13,19 292:9,11 292:17,18,21,25 293:1 293:12,12,16,23 294:15 295:6,20,21 296:7,7,12 296:20,20 297:19,25 304:14 307:13,13 308:11 308:17,20,22 309:8 312:2 313:1,2,5 314:10 315:22 315:23 316:7,15 317:8 317:11,21 319:6,15,17 319:24 320:17,22,23 321:22 322:15 323:9,18 324:4 328:15 draft [5] 40:3 70:16,18 71:4 176:9 dramatically [1] 184:6 drastically [1] 256:14 draw [1] 31:23 drawn [2] 295:13 318:17 drop [1] 169:5 dual [1] 189:22 due [4] 274:15,16,24 335:11 during [24] 12:11 13:12 17:5 71:3 113:4 173:11 195:10,17 220:21 221:1 221:4 236:8 254:20 259:6 260:9 272:18 275:7 284:12 293:25 297:8 303:1,9 335:10 341:8 duties [6] 60:21 152:24 205:18 361:13 374:10,15 duty [1] 335:16 Dyer [36] 44:20 48:2 51:10 59:7,13,16,18 60:1 62:21 63:8 64:4,7 66:12 66:13 69:25 70:3 93:7 95:1,7 96:2 120:25 129:1 129:22 130:11 154:11 155:3 221:23 223:2 246:14 285:15 286:5,12 290:10 293:18 294:2 296:19</p>	<p>Dyer's [1] 153:14 Dynacare [2] 56:20,25 <hr/> -E- <hr/> e [7] 188:21 207:17,17 213:25,25 242:24 244:4 e-mail [13] 76:2 84:3 92:1 105:17 106:5 117:2 117:4 152:3 192:8,13,19 266:18 328:9 e-mails [1] 73:15 early [6] 102:15 110:4 128:17 154:6 219:17 256:24 Eastern [41] 1:10 23:13 70:7 73:13 75:8,11,12 76:10,12 80:25 81:6 86:7 93:19 108:8 116:19 120:15 150:10 159:13 161:2,7 162:6 229:20 265:22 282:13 283:23 284:4,9,11,15,19,25 299:11 325:7,12,18 334:17 336:18 337:11 356:7 371:25 375:6 eat [1] 346:13 educate [1] 363:9 educated [3] 361:24 362:23 374:11 education [8] 196:9 314:25 350:20 357:15 359:13 363:3 364:6,18 educational [3] 73:16 348:16 350:20 Edward [1] 353:6 effect [3] 137:22 216:24 307:16 effectively [2] 216:5 231:4 effectiveness [1] 277:1 effects [3] 354:8,14,16 efficient [2] 27:14 28:6 effort [2] 140:3 188:11 EIA [2] 178:18 196:21 eight [4] 23:20 168:5 304:24 328:19 eight-year [2] 77:17 79:20 either [31] 9:1 11:12 15:17 16:11 37:23 42:25 43:12,22 44:3 60:16 63:8 63:11 79:6 80:16 96:1 114:12 123:22 130:18 134:10 142:20 152:1 153:20 212:6 226:8 260:3 261:20 298:13 306:11 307:18 328:3 330:15 Ejckam [43] 17:9 18:2 18:11 60:9 61:2,13,19 61:22 62:4,17,20,22 63:24 64:1,16 65:21 66:5 66:16 213:1 223:3,12,18 248:7,8 285:5 286:22 289:19,23 290:2,6 291:14 292:11,22 295:6,15,21 296:2,7,8,13,20 308:12</p>	<p>308:22 Ejckam's [10] 59:2 60:16 63:6 66:12,19 248:10 292:19 293:13 308:17,20 elaborate [1] 125:4 elect [2] 19:14 20:8 elected [1] 19:8 eliminate [1] 262:13 Elliott [3] 375:7,19 376:2 Elms [3] 129:25 130:16 215:12 Elms' [1] 130:4 elsewhere [1] 327:4 embedded [2] 54:19 84:9 embedding [1] 213:23 Eminent [1] 309:13 emotional [1] 193:2 emphasizing [1] 66:3 employed [2] 297:9 348:20 employees [1] 23:13 emulsifying [1] 197:13 emulsion [3] 179:2,5,9 encountered [2] 129:7 224:4 end [15] 52:21 61:7,8 63:7 82:20 152:6,11 217:4 225:23 245:17 281:6 292:3 349:9 362:13 366:16 ended [3] 29:8 140:23 324:22 endure [1] 325:9 engaged [2] 55:21,23 engaging [1] 120:16 engineer [1] 353:7 engineering [8] 6:16 7:2 55:23 354:6,19 371:5,12 371:23 enhance [1] 369:9 enlighten [1] 303:14 enormous [1] 335:19 enrole [1] 213:3 enrolled [5] 67:20 68:1 68:7,11 211:21 ensure [2] 5:10 55:7 82:10 106:13 153:14 154:13 187:13,17 189:1 189:10 190:19,23 199:5 202:13 203:4 210:18 213:15 278:11 279:3 337:11 369:2 ensuring [3] 82:13 277:10 317:15 enter [4] 155:9 243:3 327:22 366:19 entered [30] 157:6 305:17 331:18 346:11 347:12,13,14,15,16,17 347:18,19,20,21,22,23 347:24,25 348:1,2,3,4,5 348:6,7,8,9,10,11,12</p>
---	--	---	---	---

<p>entering [2] 154:2 155:1 entire [5] 174:24 340:8 340:11 362:2 370:15 entitled [1] 263:5 entries [8] 123:18 124:21 133:24 134:16 151:24 328:20 330:15,23 entry [6] 131:13 134:13 304:13 329:5 330:3,4 environment [5] 9:9,9 9:10 20:20 355:3 envisaged [1] 53:1 envisioned [1] 52:21 enzyme [3] 178:17 180:20 196:21 epidemiologists [1] 120:22 epidemiology [1] 360:8 epitope [1] 229:22 equipment [13] 5:17,18 5:22,24,25 9:24 10:2,7,9 179:2 199:11 290:15 296:18 equivalent [2] 313:12 313:14 equivocal [1] 260:20 ER [74] 26:10 82:1,4,6 82:19 87:2 98:13,15 100:23 112:7,9,17 115:6 117:9,10 121:2 123:21 124:11 125:12 126:12,25 127:17,24 129:3 131:3 131:12,13,25 132:3,15 134:3,14,22,24 135:1,4 135:21 141:5,23 142:6 146:11 159:14 164:13,14 164:15,15,20 165:7,9,10 165:15,15,21 166:11 178:20 209:18,18 247:21 249:20,23 250:2 252:1 259:10 297:5,10 329:2,3 329:15 330:9 331:12,20 332:8,20 333:6 ER/PR [78] 25:17 27:12 31:17 34:19 37:22 40:14 73:3,15 76:3,24 84:18 84:19 86:10 162:15,22 163:14 178:13 183:4,7,9 184:7,12,21 196:19 197:5 198:20 205:11,20 209:11 223:24 225:25 226:23 228:4,7 230:6 236:4,21 236:24 237:14,19 239:7 244:4 245:5,9 246:11,19 246:25 247:15,17,23 248:9 251:21 254:22 257:21 258:9,12,18 263:5 264:7 274:23 278:1 300:19 301:5,12,16 303:18 304:15,23 305:23 306:6 310:1 313:13 314:9 315:5 322:6 324:15 338:19 340:8 error [1] 144:1 escalate [1] 63:10 essence [1] 374:3 essentially [2] 82:18 163:18</p>	<p>establish [2] 178:13 204:1 established [6] 34:5 219:15 271:24 322:9 323:4 370:1 establishment [1] 247:22 estimate [5] 92:13 199:16 269:22 302:13 319:17 estimated [4] 291:1 313:21 319:9,19 estimation [2] 268:23 319:4 estrogen [2] 26:10 179:8 et [2] 1:9 73:17 etc [3] 234:2 235:17 246:16 evaluating [1] 353:19 event [1] 191:8 events [2] 113:1 116:20 everywhere [1] 364:22 evidence [18] 80:4 99:4 102:13 105:3 110:2 126:21 127:8 138:23 148:19 150:19 239:2 245:15 248:13 253:22 254:6 265:15 286:1 324:21 evolutions [1] 11:6 evolved [1] 153:7 exact [6] 92:6 100:6 194:24 220:12 247:17 302:8 exactly [13] 41:10,11 98:23 164:7 222:21 241:19 247:8 312:24 352:7 359:18 365:3,9 369:12 exam [4] 4:24 5:3,5 20:17 examination [13] 2:3,4 2:5,6,7,9 4:3 9:2 72:15 177:16 328:4 338:4 345:17 example [23] 7:18 19:15 21:7 29:4 67:23 143:4 144:5 149:6,8 160:6 172:22 173:1 190:8 201:6 211:18 225:21 227:5 321:7 332:6 342:24 352:9 354:18 369:5 examples [2] 165:14 365:20 Excel [1] 366:21 excellent [3] 66:21 267:6 267:9 except [2] 34:6 252:8 exception [4] 68:19 82:14 223:19 322:2 excessive [1] 252:20 exclude [1] 265:4 excluded [4] 87:20,23 331:5 333:8 excluding [1] 264:13</p>	<p>excuse [2] 23:4 267:18 executive [4] 19:19 20:3 57:14 81:8 exercise [5] 120:3 161:2 163:13 164:1 168:2 exercising [1] 280:1 exhibit [27] 3:6,12,16,18 3:19 31:7 64:9 84:2 86:5 105:8 106:20 123:15 134:13 151:24 230:25 232:17 269:9 297:17 300:23 328:7 338:12,13 347:16,22 348:1,3,4 exhibits [46] 3:2,3,4,5,7 3:8,9,10,11,13,14,15,17 3:20,21,22,23,24,25,26 3:27,28 135:7 339:10 346:10 347:4,13,14,15 347:17,18,19,20,21,23 347:24,25 348:2,5,6,7,8 348:9,10,11,12 existed [2] 28:1 121:21 existence [1] 29:11 existing [5] 30:18,18 288:10 290:19 316:10 expand [1] 24:4 expanding [3] 21:23,24 28:20 expect [10] 102:4 116:4 116:4 187:23 200:19 279:22 310:25,25 319:18 341:11 expectations [2] 99:23 271:25 expected [8] 99:1,15 101:5 102:16 103:18 310:6 339:22,25 expecting [1] 340:1 expenditures [1] 334:11 expense [1] 200:1 expensive [2] 47:8 199:9 experience [5] 18:22 218:22 244:1 302:23 323:17 experienced [1] 277:3 expert [5] 102:19 207:8 207:16,22 317:12 expertise [5] 31:2 208:1 246:5 316:4 323:14 experts [10] 98:25 99:5 99:15,23 101:6 102:3,5 102:15,16 103:19 explain [10] 151:23 152:1 162:19 176:3 187:7 188:6 190:21 226:2 253:10 264:1 explained [5] 186:12 190:18 191:9 250:7 297:18 explaining [1] 189:8 explanation [3] 124:3 131:22 137:24 explore [2] 355:16,22 exploring [1] 22:12 express [2] 120:2,7</p>	<p>expressed [1] 162:5 expressers [1] 83:13 extensive [1] 37:1 extensively [1] 60:8 extent [3] 198:3,6 325:8 external [17] 42:23 67:21 68:7,11,22 69:6,8 210:1 210:10 211:15,21,24 212:17 250:17 252:17 274:25 276:24 externally [1] 21:14 extra [1] 199:25 extract [2] 257:14 276:18</p> <hr/> <p style="text-align: center;">-F-</p> <hr/> <p>f [1] 207:17 face [2] 171:14 325:2 facilitator [8] 349:2 356:14,19,21 361:17 362:13 370:5 371:6 facilitators [9] 356:25 358:20 366:18 369:21 372:17,21 373:7 374:7 374:16 facilities [2] 53:21 58:1 facing [1] 295:22 fact [22] 25:16 32:25 40:7 46:21 54:23 57:6,8 126:3 126:21 138:24 178:16 184:24 197:6 202:5 218:11 233:3 237:6 240:3 255:20 267:8 286:5 310:13 factors [3] 139:7,11 274:17 failure [3] 354:7,11,14 fair [7] 25:22 218:21 291:1 292:16,21 324:19 324:23 fairly [8] 16:17 17:3 27:19 173:1 201:13 204:2 293:3 368:1 fall [4] 208:14 266:7 373:6 374:3 falls [4] 121:8 202:12,12 333:12 false [50] 80:6,9,17,18 92:19 96:15 98:21 99:1 99:6 103:5,24 104:6 109:4 143:8,10,23 144:3 144:11 145:7,11 146:14 146:16,23 147:6,18,23 148:9,15,24 149:5,7 150:17 151:11 161:16 162:3 252:24 253:1,3 262:13,19 298:5,9,17 299:13 302:14 307:20 308:25 312:18,19,20 familiar [22] 31:14 40:25 42:9,12 86:11,18 92:21 105:19 106:22,24 117:11 123:16 134:11 135:9,17 135:23 147:3 151:19,20 176:4,15 328:13 families [2] 335:5,25 family [1] 335:5</p>	<p>fantastic [1] 193:18 far [7] 53:22 151:6 156:6 178:21 191:10 267:24 299:11 fashion [3] 25:23 117:23 186:21 fashions [1] 25:18 faster [1] 256:1 favour [1] 246:21 fe [1] 235:23 February [2] 167:10 191:6 feedback [9] 31:12 39:16 188:19,23 209:22 311:24 352:1 357:23 367:3 feelings [1] 205:18 feels [2] 205:25 326:17 fell [1] 331:20 felt [6] 14:19 54:1 161:1 292:12 335:16 376:5 few [9] 133:24 140:14 195:3 221:25 239:18 285:8 313:7 334:3 344:16 fewer [3] 100:7 107:7 140:9 field [1] 317:13 figure [10] 73:2 77:3 107:22,23 111:2,22 177:18 266:10 307:3 349:18 figured [1] 319:20 figures [2] 110:18 265:20 file [2] 120:13 191:25 filed [1] 338:14 files [6] 192:1 261:9,11 261:15,17 367:15 fill [2] 219:8 304:9 filled [2] 219:5 365:19 filling [1] 369:6 final [6] 40:8 44:23 182:17 239:11 301:14 328:17 finalize [1] 163:15 finally [2] 69:19 333:23 financial [8] 187:14 190:20 200:7 288:18 289:11,20 315:12 334:10 financing [1] 288:7 finding [3] 139:11 166:9 305:16 fine [1] 210:19 finish [1] 351:3 firm [1] 340:13 first [44] 4:15 5:14 18:25 22:19 36:15 59:4 84:15 86:23 111:6 127:14 130:19 136:2 169:11,16 172:22 174:13 191:17 205:25 207:9 209:10,10 231:22 232:5 235:4 237:17 246:23 255:12 256:20 257:2,4 276:18 285:9,13 292:14 298:14 323:19 329:4,8,14 364:16</p>
---	--	---	---	---

<p>366:12,13 369:14,15 fiscal [1] 174:14 fish [1] 353:24 fit [1] 360:9 fits [1] 360:21 five [14] 24:18 35:17 80:13 134:25 135:14 141:24 165:10 168:4 169:4 222:21,22 263:11 264:7 345:6 fix [2] 65:20,20 fixation [8] 14:4,5,7 15:19 64:18 66:22 321:12 336:6 fixed [3] 16:10,22 316:21 floor [2] 368:9,10 flow [2] 67:23 353:23 fluctuating [1] 355:4 focus [12] 73:5 74:21 75:23 112:17 113:10 126:13 353:4 357:9 360:16,17,19 364:14 focused [5] 73:7 77:5 112:21 139:17 335:21 focusing [6] 73:24 77:1 116:20 144:21 145:3 149:6 follow [8] 5:10 244:3,5 269:8,13 293:5 366:8,25 follow-up [1] 291:13 followed [8] 4:24 16:1,5 201:23 244:3 269:9 340:9 369:8 following [6] 67:5 117:5 231:5 292:18 311:22 364:12 Fontaine [1] 307:13 foot [2] 256:2,4 footnotes [1] 297:18 Ford [3] 129:25 130:18 215:12 foregoing [1] 377:2 forever [1] 4:18 forget [1] 224:11 form [6] 192:14 304:10 304:10 323:13 361:25 365:11 formal [3] 219:19,24 220:20 formaldehyde [2] 50:2 50:15 formalin [8] 16:12 48:23 49:1,4,10,20 50:20,24 format [8] 25:5 29:6,10 156:20 310:23 339:25 366:21 372:15 formation [1] 371:24 formats [1] 311:3 forms [1] 291:16 formula [1] 51:2 forth [2] 51:12 309:14 fortunately [1] 114:15 forward [5] 4:16 52:16 55:19 64:3 318:1</p>	<p>found [8] 84:22 171:6 201:17 274:6 286:5 297:1 307:18 360:9 four [37] 11:3 24:18 35:17 84:24 87:7 92:7 97:24 98:8 99:12 107:5 107:23 109:9,20,22,23 110:4 111:6,15 135:12 140:9 148:19 167:20 175:25 222:21,25 223:2 249:22 250:1,1,2 255:20 255:23 288:5 317:3,4 328:21 347:4 frame [17] 17:5 41:11 70:22 77:17 79:21 121:13 137:14,17 173:12 194:25 195:6 220:12 221:5 222:18 254:20 275:14 292:25 framed [1] 281:20 free [3] 24:25 60:21 235:23 freeing [1] 293:22 freezing [1] 228:5 frequency [2] 147:18 149:5 frequently [1] 208:24 fresh [3] 178:25 196:25 295:16 friend [2] 268:7 335:11 friends [2] 335:6,9 front [2] 225:23 366:16 front-line [2] 348:21 349:18 frontline [6] 357:16 363:1,15,17 364:14,21 frozen [8] 56:5,6,9,15 179:1,1 196:22 197:1 fulfilment [1] 280:2 full [14] 58:14 147:21 148:9 149:14,16 151:16 156:10 158:21 174:16,16 191:4 290:7 335:14,18 fulltime [3] 60:23,25 314:22 fully [2] 192:25 194:3 function [14] 6:15 188:17 202:9 207:21 215:14 216:4 217:6 277:10,17 278:12 279:5 279:8 293:21 304:21 functioned [1] 216:6 functioning [1] 209:5 functions [4] 187:22 213:22 214:5 353:3 fund [1] 315:17 fundamentally [1] 368:19 fundamentals [2] 352:4 352:22 funding [2] 201:17 314:24</p>	<p>gain [1] 19:23 gained [3] 337:3,8,9 gamble [1] 287:25 Gander [1] 121:8 gather [6] 27:1 94:23 101:7 115:24 229:25 261:19 gathered [3] 101:13 230:5 261:21 gathering [1] 72:25 gee [1] 124:10 general [16] 8:11 9:6 68:15 79:17 86:19,21 103:4 120:9 126:1,23 187:23 196:13 246:20 257:22 334:13,22 generally [9] 5:15 75:3 81:12 86:12 88:4 117:11 166:7 247:15 343:19 generated [1] 152:18 generic [1] 297:4 genetics [2] 67:24 68:24 gentleman [2] 221:8 223:20 gentlemen [1] 345:9 genuinely [1] 83:19 George [2] 55:16 57:12 given [24] 17:7,21 23:3,4 51:2 55:11 60:10,17 66:14 133:25 136:9 139:16 154:25 171:8,9 176:11 204:17 233:3 238:14 274:2 315:4 319:17 337:13 354:19 giving [9] 61:15 104:12 195:14 196:12 219:5 228:2 260:6 326:8 327:5 glass [3] 231:9 256:21 318:5 glean [2] 135:22 159:5 glorified [1] 320:19 glue [2] 256:21,23 goal [5] 313:12,12,15,18 337:17 goals [1] 357:2 goes [7] 41:16 58:11,11 243:2 247:20 256:8 362:15 gone [3] 301:4 306:23 317:14 good [24] 4:5,10 12:19 27:19 72:17,19 99:14 133:16 187:4 189:11 245:23 246:10,14 247:9 248:14 276:19 291:6 299:24 318:12 335:3 336:4 346:2,4 369:5 governance [1] 19:21 Government [1] 336:18 Gown [4] 267:13,20 268:7 297:1 Gown's [1] 270:11 Grace [9] 18:8,8,9 28:17 28:21 52:12 53:3 121:9 370:6</p>	<p>Grace/St [1] 16:19 graduate [1] 350:25 graduated [1] 348:18 grams [1] 50:16 Grand [1] 121:8 greater [2] 131:3 147:6 Green [3] 45:8 46:24 278:3 Gregory [1] 176:6 grey [1] 145:25 gross [1] 16:23 grossed [2] 16:13 316:22 grossing [6] 17:15 290:13 293:21 314:19 317:2 321:12 ground [1] 327:23 grounded [1] 324:20 group [23] 18:7 74:4 82:24 83:5,12,16,22 84:13 85:9 86:23 89:4 96:11 106:5,9,9 107:7 112:10 140:3 286:11 303:7 357:1 368:3,13 groups [2] 30:12 119:6 guarantee [1] 342:4 guess [79] 4:22 5:17,24 6:23 8:14 9:22 10:13 12:4 13:1 17:22 18:23 21:4 23:5,25 35:3,7 40:15,23 41:15 42:7 44:11 45:8,25 46:6,17 46:20 48:24 52:20 66:5 68:14 70:13 71:22 74:21 76:11 77:5 79:16,17 86:21 90:14 93:21,23 109:4 144:21 152:25 171:5 178:16 187:12,19 189:24 195:1 197:3 202:16 203:19,20 206:5 210:17 214:23 222:5 226:8 231:21 233:4 236:1 243:6 245:16 248:20 252:23 259:21 281:2 299:3 300:11 306:21 321:3 352:25 353:16 355:5 363:8 365:16 366:3 372:14 guessed [1] 238:13 guessing [1] 307:17 guesstimate [1] 107:12 guidance [9] 88:2 219:6 219:14 248:11 280:12,14 280:24 281:3 314:10 guidelines [5] 65:6,15 66:24 152:5 299:4 Gulliver [976] 2:2 4:3,5 4:9,17 5:2,6 6:1,6,14,19 7:3,8,13 8:9,19 9:4,17 10:3,8,14,19 11:2,9,14 11:20 12:7,22 13:4,17 13:24 14:12,20,24 15:6 15:13,20 16:2,6 17:1,2 17:12 18:3,18 19:6 20:6 20:12,25 21:8,15 22:1,7 22:16,22 23:9 24:6,13 24:24 25:9,21 26:13 27:4 27:8,16 28:9 29:22 30:3</p>	<p>30:17 31:3,6 32:8,22 33:6,13,22 34:3,13,17 34:23 35:10,25 36:4,11 36:19,22 37:11,15,24,25 38:4,8,13,18 39:1,17 40:10,19 41:4,9,21 42:11 42:17 43:3,8,13,18,23 44:7,19 45:3,7,16,20 46:8 47:3 48:11,16,20 49:11,18,23 50:7,25 51:13,25 52:6,10 53:2 53:14,18 54:10,18 55:1 55:6,14 56:8 57:10,24 58:21 59:8,14,21 60:2 60:13,20 61:21 62:5,13 62:19 63:16,25 65:1,9 65:14,19 66:4,18 67:13 67:14,19 68:6,21 69:4 69:14,19,20 70:2,10,19 71:11,23 72:1,2,15,17 72:18,23 73:20 74:1,10 74:24 75:7,13,17 76:5 76:14,21 77:7,11 78:6 78:13,24 79:3,12 80:2 80:24 81:5,13,21 82:7 82:22 83:7,21 84:4,5 85:6,11,21 86:2,14,20 87:11,21 88:5,13,18,23 89:6,10,11,18,24 90:6,9 90:15,19,23 91:2,11,17 91:23 92:5,22 93:3,8,13 93:20,25 94:8,13,25 95:8 95:14,21 96:3 97:2,7,13 97:17 98:2,7,20,24 99:19 99:25 100:9,17,25 101:14 101:18,22 102:6,18 103:3 103:9,13,21 104:7,16,24 105:22 106:1,8 107:1,9 107:13,17,25 108:5,10 108:15,21 109:1,6,14,19 110:9,15,19,23 111:5,11 111:18 112:3,12,16 113:3 113:7,13,20 114:2,19,24 115:3,10,16 116:1,11,15 117:13,20,25 118:4,9,16 118:25 119:10,15,19 120:4,8 121:3,17,23 122:3,8,12,17,23 123:6 123:11,14,25 124:5,13 124:17,23 125:6,15,20 125:24 126:10,17,24 127:4,16,21 128:2,7,12 128:21 129:8,12,17,24 130:6,12,17,22 131:5,23 132:4,19,24 133:4,10,24 134:6 136:1,11,19,24 137:5 138:1,10,14 139:5 139:13,24 140:12 141:1 141:6,10,19,25 142:11 142:18,24 143:7,11,17 144:4,10,14,18,25 145:5 145:12,16,20,24 146:4,8 146:13,19,24 147:8,12 147:20 148:4,11,16 149:1 149:15,21 150:4,8 151:1 151:5,15,25 152:3,24 153:5,10 154:5,10,22 155:4,8,13,17,22 156:5 156:9,13,17,22 157:2,10 157:20,25 158:6,11,16 159:7,10,17,22 160:11 160:17 161:11,18,23 162:7,11 163:4,8,12,19</p>
--	--	--	---	--

-G-

g [3] 207:17,17 213:25

<p>163:24 164:6,17,22 165:1 165:5,17,22 166:1,13,18 166:23 167:4,9,13,19,24 168:10,15,23 169:2,10 169:15 170:1,6,14,19 171:10,18 172:1,9,16,20 173:3,10,19 174:2,6,12 174:21 175:1,5,11,15,19 176:16,23 177:3,10,12 177:16 178:7,22 179:7 179:12,18 180:6,10,14 180:25 181:13,19 182:1 182:5,9,15 183:3,8,12 183:22 184:2,8,18 185:1 185:7,16,21 186:3,9,16 186:22 187:3,11 188:3,7 189:5,13,18 190:3,7,22 191:12,22 192:2,6,15,18 192:24 193:9,14,24 194:5 194:14,23 195:11,19,24 196:10,24 197:8,14,19 197:25 198:5,15,23 200:11,15 201:9 202:1 202:15,19,25 203:7,18 204:7 205:2,6,12 206:6 206:11,15 207:13,19 208:4,15,22 209:14 210:2 210:11,16,23 211:2,6,13 211:19 212:5,14,20,24 213:7,12,18 214:9,14 215:1,5,11,15,20,25 216:8,14,19 217:1,8,17 217:22 218:8,13,17,25 219:7,21 220:1,5,11,17 220:22 221:3,10,15,20 221:24 222:4,8,13,17,23 223:8,13 224:1 225:1,9 225:17,22 226:3,11,20 226:25 227:9,21 228:18 228:25 229:11,16,21,24 230:4,13 231:6,12,17,24 232:4,12,20,25 233:6,12 233:16 234:4,7,8,15,21 235:10,20,25 236:13,17 236:22 237:9,15 238:5 238:10,17 239:5,13,22 240:5,21 241:3,8,13,18 241:24 242:7,15,19 243:7 243:12,16,20,25 244:15 244:23 245:3,10,15,20 245:25 246:7,13,17 247:5 247:16 248:4,16 249:4,8 249:12,18 250:10,14,18 250:23 251:6,11,23 252:10,14,25 253:7,12 254:3,8,14,19 255:2,9 255:14 256:10 257:19 258:4,10,19 259:9,23 260:2,10,22 261:1,12,16 262:2,9,15,20 263:2,8 263:18 264:2,15,20 265:10,19 266:24 267:10 267:14 268:12,19 269:3 269:16,23 270:7,12,16 271:7 272:4,9,19 273:2 273:16 274:12 275:2,6 275:21 276:9,15,22 277:6 277:13,19,23 278:14,20 278:25 279:6,11,16 280:3 280:8,21 281:4,18 282:5 282:23 283:6,9,14,22 284:2,14 285:1,17,22 286:4,10,18 287:16 288:1</p>	<p>288:9,23 289:4,8,14,22 291:17 292:2,6,13,20 293:8,14 294:9,14,19,23 295:3,8,17,24 296:5,14 297:14,18 298:12,18,22 299:2,14 300:7,14,25 301:11,21 302:2,7,15,20 303:3,10,21 304:1,5 305:5,11,19 306:2,13,17 306:22 307:5,12,22 308:5 308:15 309:3,9,16,20 310:2,12,17,21 311:13 311:19 312:6,11,16 313:8 313:16,24 314:6,13 315:19 316:18 317:20 319:1,13 320:14,21 321:20 322:12,25 323:7 323:15 324:3,20,23 325:20 326:16 327:12 328:2,4,24 329:10,18,22 330:6,12,18 331:1,7,14 331:22 332:2,13,17,22 333:1,9,17,20,22 334:1 336:8 337:25 338:4,8,21 339:2,11,15 340:2,5,12 340:18,23 341:2,14,20 342:3,9,15,20 343:7,13 343:18,24 344:5,9,15,17 344:22</p>	<p>23:13 28:4,18,19 29:10 35:23 45:11,13,15,23 46:7,21 47:15,15,20 48:1 48:5,6 52:22 53:5,8 54:20 56:22 57:18 58:22 65:11 70:7 73:13 75:8 75:11,12 76:10,11,12 80:25 81:7 86:7,8 93:19 108:8 116:19 119:2 120:15 121:9 150:10 159:13 161:2,7 162:6 216:21 218:2 219:11 229:20 265:22 282:13 283:23 284:9,11,15,19 284:25 290:11 299:11 320:11 325:7,12,18 334:9 334:12,17,22 336:19,21 337:1 349:3,5 351:1 354:17 356:7,10,12,19 356:22 359:22,24 364:15 365:10 369:15,24 370:6 371:25 375:6</p>	<p>himself [3] 95:18 195:1 325:22 hindsight [4] 17:21 18:10 68:18 315:9 hire [2] 315:5 317:3 histochemical [1] 242:23 histochemistry [1] 197:5 Histogrip [1] 47:7 histological [1] 181:12 histology [17] 21:22 179:17,22 180:13 182:13 182:24 184:13,13,23 186:7,7,14 189:25 197:17 203:5 204:5 315:14 history [5] 128:16 228:2 351:24 352:25 376:7 hold [4] 130:19 220:20 220:25 374:20 home [1] 15:21 Honourable [2] 1:3 377:6 hope [4] 44:22 337:7,13 346:14 hopefully [1] 338:7 hormone [21] 1:2 73:9 77:19 78:16 79:7,7 80:16 114:8,20 127:25 128:15 136:9 140:15,17,21 150:22,23 185:6,20 196:15 377:4 hospital [10] 52:12 58:8 58:14 321:5 348:21 349:1 350:23 351:18 353:3,4 hospitals [7] 28:2 65:6 65:16 321:9,9,14 355:3 host [1] 295:21 hosted [1] 13:7 hot [20] 227:5,7,15,18,19 228:13,23 229:4,13 230:23,24 231:1,3,20 232:7 233:15,17 238:19 240:8,16 hotline [1] 24:23 hour [1] 376:6 hours [5] 77:21 81:25 82:5 279:20 336:2 house [1] 49:5 Howell [3] 81:16 84:11 266:19 huge [1] 337:3 human [6] 288:17 289:11 289:19 315:11 323:13 325:2 hundred [2] 301:10,24 Hundreds [1] 243:17 Hutton [2] 297:19,25</p>	<p>308:22 326:9 ideal [2] 251:7,9 Ideally [1] 253:5 identified [5] 82:18 96:12 288:6 328:22 333:5 identifying [2] 73:8 77:21 identifying [2] 252:19 335:22 IHC [86] 10:24 11:6,8 12:2,5 13:16,18,20 21:7 21:22 33:5,15 35:5 45:24 46:22,25 47:5,18 60:18 60:23,25 61:18,18 62:24 63:1,2 65:11 67:22 68:9 69:1,7 180:7,9 182:12 182:23 183:4,16 184:22 186:8,20 187:9,12 188:22 199:17 200:24 201:13 205:20 208:8,10 211:25 215:2,4,17 216:25 217:13 217:25 218:7,14,21 221:2 223:24 225:23 236:2,5 237:19 239:9 242:23 248:7 254:23 257:22 258:6 261:6 277:25 278:5 285:23 286:24 290:6 293:21,23 304:9 309:14 314:9,25 316:2 323:17 323:23 imaging [1] 368:8 immerse [1] 238:24 immuno [3] 178:17 180:20 196:21 immunohistochemical [4] 204:25 214:1 248:1 313:13 immunohistochemistry [8] 35:5 206:3 207:9,18 228:9 246:16 247:11 285:16 immunology [1] 279:18 immunoperoxidase [2] 234:13 235:18 impact [2] 148:25 149:8 impacted [2] 144:22 334:6 implementation [1] 195:12 implemented [3] 71:17 194:7 195:13 implications [3] 71:8 153:18 185:15 imply [1] 262:7 importance [6] 34:12 49:15 56:5 66:22 256:8 295:22 important [10] 113:22 113:25 118:7 256:25 257:15,17,20 288:18 364:20 365:25 importantly [1] 337:21 impressed [2] 201:13 323:22 improve [1] 357:9 improved [5] 308:23 336:6,10,12,14</p>
<p>-H-</p>		<p>Health's [2] 284:4 337:11 hear [5] 127:14,17 309:10 325:6 338:7 heard [44] 8:15 11:5,25 14:3 21:24 45:7 48:23 49:5,14 61:14,14 64:11 74:16 98:25 110:22 111:6 111:6 116:18 120:10 127:5 128:3,13,13 138:24 139:6 201:11 209:16 217:11 223:3 265:25 281:19 289:25 309:15,17 309:25 311:12 323:18 334:4 336:4,5,9,11,14 377:5 heat [8] 225:15,16,18 229:3,7 232:6 239:19 240:11 Heather [13] 2:8 55:22 81:17 84:13 92:1 105:15 106:11,21 156:1 328:10 345:15,17,23 heavily [1] 311:23 held [3] 37:6 349:8 374:4 help [13] 19:20,24 95:2 160:1 196:18 223:23 232:11,16 253:2 256:12 290:15 335:17 337:16 helped [4] 12:9 47:10 335:7 350:14 helping [1] 94:23 hematology [2] 67:25 68:24 Hennebury [1] 1:9 hereby [1] 377:2 herself [1] 216:24 Hewlett [5] 13:2,13 49:5 64:11,17 high [7] 17:21 18:4,6 147:17 165:20 171:6 229:22 higher [5] 177:8,8 239:25 333:7 363:8 highest [2] 171:19,20 highlighting [1] 137:10</p>	<p>-I-</p>	<p>i.e [2] 9:7 314:18 idea [10] 91:24 93:23 131:19 141:14 142:16 168:8 207:25 225:8</p>
<p>h [8] 188:21 207:17,17 213:25,25,25 242:24 244:4 H-E-A-T-H-E-R [1] 345:23 Haegert [3] 185:24 195:2 199:14 half [4] 222:5,7 223:2 376:6 hand [1] 199:6 handbook [2] 12:14 255:6 handful [2] 80:11 304:21 handled [1] 156:18 handles [1] 152:22 hands [1] 286:3 handwriting [2] 234:13 310:10 happening [3] 113:2 139:21 364:23 happy [1] 328:2 harboured [1] 193:7 hard [4] 25:18 30:20 267:2 288:16 hardly [1] 326:11 hate [1] 108:1 he'd [1] 64:2 head [6] 214:20 215:9,22 216:5 221:1 326:12 headed [1] 39:9 heading [2] 162:24,24 278:25 279:6,11,16 280:3 280:8,21 281:4,18 282:5 282:23 283:6,9,14,22 284:2,14 285:1,17,22 286:4,10,18 287:16 288:1</p>	<p>h [8] 188:21 207:17,17 213:25,25,25 242:24 244:4 H-E-A-T-H-E-R [1] 345:23 Haegert [3] 185:24 195:2 199:14 half [4] 222:5,7 223:2 376:6 hand [1] 199:6 handbook [2] 12:14 255:6 handful [2] 80:11 304:21 handled [1] 156:18 handles [1] 152:22 hands [1] 286:3 handwriting [2] 234:13 310:10 happening [3] 113:2 139:21 364:23 happy [1] 328:2 harboured [1] 193:7 hard [4] 25:18 30:20 267:2 288:16 hardly [1] 326:11 hate [1] 108:1 he'd [1] 64:2 head [6] 214:20 215:9,22 216:5 221:1 326:12 headed [1] 39:9 heading [2] 162:24,24 278:25 279:6,11,16 280:3 280:8,21 281:4,18 282:5 282:23 283:6,9,14,22 284:2,14 285:1,17,22 286:4,10,18 287:16 288:1</p>	<p>h [8] 188:21 207:17,17 213:25,25,25 242:24 244:4 H-E-A-T-H-E-R [1] 345:23 Haegert [3] 185:24 195:2 199:14 half [4] 222:5,7 223:2 376:6 hand [1] 199:6 handbook [2] 12:14 255:6 handful [2] 80:11 304:21 handled [1] 156:18 handles [1] 152:22 hands [1] 286:3 handwriting [2] 234:13 310:10 happening [3] 113:2 139:21 364:23 happy [1] 328:2 harboured [1] 193:7 hard [4] 25:18 30:20 267:2 288:16 hardly [1] 326:11 hate [1] 108:1 he'd [1] 64:2 head [6] 214:20 215:9,22 216:5 221:1 326:12 headed [1] 39:9 heading [2] 162:24,24 278:25 279:6,11,16 280:3 280:8,21 281:4,18 282:5 282:23 283:6,9,14,22 284:2,14 285:1,17,22 286:4,10,18 287:16 288:1</p>	<p>h [8] 188:21 207:17,17 213:25,25,25 242:24 244:4 H-E-A-T-H-E-R [1] 345:23 Haegert [3] 185:24 195:2 199:14 half [4] 222:5,7 223:2 376:6 hand [1] 199:6 handbook [2] 12:14 255:6 handful [2] 80:11 304:21 handled [1] 156:18 handles [1] 152:22 hands [1] 286:3 handwriting [2] 234:13 310:10 happening [3] 113:2 139:21 364:23 happy [1] 328:2 harboured [1] 193:7 hard [4] 25:18 30:20 267:2 288:16 hardly [1] 326:11 hate [1] 108:1 he'd [1] 64:2 head [6] 214:20 215:9,22 216:5 221:1 326:12 headed [1] 39:9 heading [2] 162:24,24 278:25 279:6,11,16 280:3 280:8,21 281:4,18 282:5 282:23 283:6,9,14,22 284:2,14 285:1,17,22 286:4,10,18 287:16 288:1</p>	<p>h [8] 188:21 207:17,17 213:25,25,25 242:24 244:4 H-E-A-T-H-E-R [1] 345:23 Haegert [3] 185:24 195:2 199:14 half [4] 222:5,7 223:2 376:6 hand [1] 199:6 handbook [2] 12:14 255:6 handful [2] 80:11 304:21 handled [1] 156:18 handles [1] 152:22 hands [1] 286:3 handwriting [2] 234:13 310:10 happening [3] 113:2 139:21 364:23 happy [1] 328:2 harboured [1] 193:7 hard [4] 25:18 30:20 267:2 288:16 hardly [1] 326:11 hate [1] 108:1 he'd [1] 64:2 head [6] 214:20 215:9,22 216:5 221:1 326:12 headed [1] 39:9 heading [2] 162:24,24 278:25 279:6,11,16 280:3 280:8,21 281:4,18 282:5 282:23 283:6,9,14,22 284:2,14 285:1,17,22 286:4,10,18 287:16 288:1</p>

<p>improvement [9] 349:8 353:10,13,15,23 357:21 371:10 373:15,22</p> <p>in-house [3] 48:25 49:7 49:9</p> <p>inaudible [4] 133:14 267:21 268:4 324:21</p> <p>incidences [3] 361:20 362:18 367:9</p> <p>incident [4] 354:2 365:5 366:4,6</p> <p>incidents [2] 374:12,14</p> <p>inclined [1] 22:20</p> <p>include [16] 28:21 44:23 109:11 111:16,23 112:7 116:8 163:22,23 164:4 164:14 166:11 205:7 265:3 363:12,17</p> <p>included [8] 87:9 88:3 111:3 112:10 137:4 328:23 335:9 356:5</p> <p>includes [2] 202:23 335:5</p> <p>including [8] 35:19 84:11,13 186:20 291:17 317:10 323:13 334:5</p> <p>inclusive [14] 346:15,16 346:17,18,19,20,22 346:23,24,25 347:1,2,4</p> <p>incomplete [1] 159:3</p> <p>incorrect [1] 185:13</p> <p>incorrectly [1] 185:10</p> <p>increase [1] 262:19</p> <p>incubate [1] 242:1</p> <p>incubation [3] 342:8 343:16,23</p> <p>incumbent [2] 14:6,8</p> <p>Indeed [1] 319:9</p> <p>independent [2] 63:23 64:17</p> <p>independently [1] 280:10</p> <p>indexing [1] 230:14</p> <p>indicate [2] 259:17 330:17</p> <p>indicated [8] 51:8 68:18 77:11,16 81:24 107:4 126:4 134:1</p> <p>indicates [1] 230:16</p> <p>indicating [3] 117:9 153:11 338:16</p> <p>indication [2] 69:11 306:8</p> <p>indicators [2] 357:3,6</p> <p>individual [7] 4:6 37:7 82:23 115:19 127:6 218:1 366:25</p> <p>individually [4] 106:10 116:16 136:2 270:18</p> <p>individuals [2] 12:3 23:25</p> <p>industries [1] 355:1</p> <p>industry [3] 353:7 355:10,11</p>	<p>infection [3] 371:8,13 372:1</p> <p>infer [2] 198:21 272:11</p> <p>informal [1] 293:6</p> <p>informally [2] 221:7 224:5</p> <p>information [68] 25:20 26:6,8,11 30:6 36:9 64:13,23,25 65:7 66:3 66:11,13 71:3,15 72:25 86:12 87:9 91:23 94:5 94:24 97:23,24 100:13 101:8 102:11 105:6,20 106:19,20,25 110:8 116:24 117:1,4,6,6,8 123:14 125:9,11 131:18 131:20 142:16 147:4 149:25 152:8 154:11 157:17,22 163:1 170:5 170:12 173:16 182:20 204:23 245:13 249:3 260:12 262:4 268:17 282:21 297:11,20 298:2 357:12 363:24 366:21</p> <p>informed [2] 95:22 364:3</p> <p>initial [3] 24:16 234:12 314:2</p> <p>initials [1] 234:3</p> <p>initiative [3] 75:20,24 76:4</p> <p>initiatives [8] 54:24 63:7 361:2 362:24 364:4,19 370:1 371:6</p> <p>input [7] 31:1 71:22,24 94:5 154:11 159:12,21</p> <p>inquiry [19] 1:1 73:12 74:17 80:4 82:21 102:13 116:17 127:15 128:3 191:15 230:7 310:14 312:2 334:11 336:4 337:10,20 377:4,7</p> <p>inside [2] 7:19,24</p> <p>instability [1] 259:18</p> <p>instance [4] 21:6 28:2 135:9,11</p> <p>instances [9] 9:11 15:22 103:17 132:14 135:16,24 139:12 150:20 366:9</p> <p>instead [1] 240:7</p> <p>Institute [1] 311:4</p> <p>institution [4] 201:8 205:1 281:13 318:15</p> <p>institutions [1] 63:15</p> <p>instrument [8] 7:15,20 7:21,24,25 8:6 24:16 297:8</p> <p>instrumentation [2] 8:17 9:21</p> <p>insurer [2] 362:5 374:13</p> <p>integrate [1] 28:6</p> <p>integrated [3] 1:10,17 27:2</p> <p>intend [1] 161:7</p> <p>intended [3] 251:20 261:24 262:3</p>	<p>intent [1] 248:13</p> <p>intention [1] 164:4</p> <p>interact [3] 63:14 207:7 208:20</p> <p>interacting [1] 223:22</p> <p>interaction [7] 176:12 189:9 201:20 207:11 218:7,11 219:6</p> <p>interactions [1] 63:12</p> <p>interactive [1] 218:19</p> <p>interest [21] 113:17,21 114:22 115:8,12,14,15 115:18,23 118:17,21 119:3,6,14 125:23 138:25 139:19,20 217:13,13 218:22</p> <p>interested [6] 96:21 139:10 162:2 166:9 233:20 251:16</p> <p>interesting [2] 157:17 272:1</p> <p>interface [1] 55:10</p> <p>interjection [1] 308:24</p> <p>internal [3] 176:9 276:23 281:23</p> <p>internally [4] 21:14 29:15 108:6 366:15</p> <p>international [1] 22:4</p> <p>interpret [2] 181:1 316:5</p> <p>interpretation [15] 26:1 26:2,21 39:21 54:21 57:1 66:23 84:23 121:12 181:17 183:18 250:4 311:25 330:20 336:13</p> <p>interpretations [5] 40:14 211:23 275:8 322:19 323:11</p> <p>interpreted [4] 170:9 182:16 185:11 210:22</p> <p>interpreting [5] 119:11 180:22 181:8 249:25 275:16</p> <p>interrogatories [7] 233:22 235:4,8 258:24 297:21 298:3 338:15</p> <p>interrogatory [1] 259:1</p> <p>interruption [1] 368:23</p> <p>intervention [3] 308:17 308:24 318:9</p> <p>introduced [4] 22:14 25:7 35:3 244:17</p> <p>introduction [2] 23:4 345:6</p> <p>invented [2] 11:15 108:6</p> <p>investigate [3] 252:1 354:2 366:4</p> <p>investigating [2] 362:4 374:14</p> <p>investigation [3] 73:18 246:24 361:20</p> <p>investigations [1] 362:17</p> <p>involve [4] 196:23 351:20 356:18 360:13</p> <p>involved [34] 74:11 81:3</p>	<p>86:15 102:19 106:15 112:20 115:4,11 118:14 120:11,22 132:7 139:7 154:20 158:24 160:19 161:1 178:25 180:21 181:8,17 195:20,21,25 198:4 199:18 228:5,11 325:5 337:1 357:15 360:3 361:18,20</p> <p>involvement [7] 6:25 91:6 117:24 152:20,25 198:11 200:3</p> <p>Irregardless [1] 341:21</p> <p>island [3] 64:14,25 66:2</p> <p>isolated [1] 238:2</p> <p>issue [32] 16:9,20 27:12 35:19 39:11 51:9,11 53:6 55:7 56:2 76:25 80:5,17 80:22 92:19 94:15 99:17 102:3 133:8 144:24 211:11 254:11 280:14,15 316:20 335:19 363:20 368:7,7,8,9,10</p> <p>issues [24] 14:3 15:16,24 17:11 19:21,22 21:19 52:25 54:8,11 55:9 143:16 159:14 214:10 223:5 247:2 295:14,14 295:21,22 296:2,13 363:8 369:9</p> <p>item [5] 39:7,8 152:12 230:21 234:19</p> <p>items [1] 27:14</p> <p>itself [6] 7:21 43:12 106:5 289:12 293:17 361:13</p> <hr/> <p style="text-align: center;">-J-</p> <p>Janeway [5] 28:18,21 52:12 53:3 370:7</p> <p>January [4] 39:24 162:21 167:10 301:2</p> <p>jar [1] 227:19</p> <p>Jardine [1] 324:6</p> <p>Jennifer [4] 1:15 2:4 72:15,21</p> <p>jeopardizing [1] 288:14</p> <p>job [8] 9:13 24:4 44:11 120:14 202:18 203:2 223:22 279:23</p> <p>jobs [3] 202:23,24 280:10</p> <p>John [2] 16:18 46:10</p> <p>John's [39] 13:7 23:12 24:17 27:5 52:2,15,18 56:1 58:23 122:15,18,18 123:9 170:9,10,13,23 201:12 228:22 263:6 269:2,14 270:5,23 271:6 272:3,12,15 273:6,14 274:6,13,15 275:11,16 316:7 323:20 377:8,11</p> <p>joint [3] 188:14 204:10 316:14</p> <p>journal [1] 63:12</p> <p>journals [4] 61:17,17 62:11 63:11</p> <p>Joy [1] 81:14</p>	<p>Judy [2] 377:2,13</p> <p>July [18] 72:24 73:7,10 73:21 75:21 77:1 118:11 118:15 119:20 152:3,10 174:18,24 282:1 291:12 320:1 342:25 343:2</p> <p>June [21] 37:6,19 59:2 60:7,12 118:15 174:18 208:16,16 216:11 217:5 223:17 275:25 276:2,4 285:10 286:17 291:15 292:23 293:24 375:5</p> <p>Justice [3] 1:3 337:19 377:6</p> <hr/> <p style="text-align: center;">-K-</p> <p>Kara [5] 1:9 81:14 105:16,16 328:15</p> <p>keep [11] 47:11 95:22 241:23 256:22 271:22 353:18,19 366:6,7,8 369:3</p> <p>keeping [1] 112:19</p> <p>Ken [2] 45:17 278:3</p> <p>kept [1] 318:3</p> <p>key [3] 26:9,15,18</p> <p>Khalifa [68] 25:6 31:10 31:11,15 32:6,14 33:14 35:3,13 37:2 39:10,13 40:3,13,20 42:12 185:25 192:8 193:5,17,19 194:8 194:21 195:8,14,17 196:8 196:11 197:24 198:9,21 198:24 200:3,17 201:1 201:10,15 208:12 209:11 209:20 212:9 216:5,11 217:4,6 218:6,18 219:8 219:9,19 223:17 244:8 244:18 245:1 275:8 278:2 314:10 315:22 316:7 317:12,21 319:6,15,17 322:15 323:9,18 324:4</p> <p>Khalifa's [1] 25:11</p> <p>kind [17] 8:21 19:20 21:9 47:21 61:23 83:2 120:17 160:23,23,24 163:15 169:17 211:14 226:13,15 298:15 325:21</p> <p>kindly [1] 288:16</p> <p>kinds [9] 19:22 21:19 22:2 61:23 106:15 158:24 162:15 199:4 341:7</p> <p>kit [6] 31:17 32:7,19 33:19,19,20</p> <p>kitchen [7] 231:3,11,20 233:17,19 238:20 240:15</p> <p>kits [2] 11:7 199:7</p> <p>knew [13] 31:16,18 109:22 110:10 118:10 119:24 196:14 245:17 293:18,24 316:16 319:14 324:11</p> <p>knowing [1] 251:17</p> <p>knowledge [41] 12:4,5 18:22 19:23 24:5 27:19 63:10 93:9 105:3 107:10 118:13 136:5 137:6</p>
---	---	--	---	--

<p>138:11 140:14 157:11 175:2 181:20 182:2 184:3 184:19 193:10 194:9 218:9 231:7 243:21 244:19 255:3 256:7 258:5 279:7 289:5 294:20 317:21 319:5 337:3,6,8 337:9 342:5,10</p> <p>knowledgeable [1] 208:8</p> <p>known [2] 209:17 249:19</p> <p>knows [2] 223:11 326:24</p> <p>Kwan [1] 128:13</p>	<p>labs [15] 20:23 21:14 47:1 47:13 48:10 58:24 64:24 119:5 256:17,18 258:2,5 258:17 284:20 312:22</p> <p>lack [4] 152:25 274:11 274:13,25</p> <p>laid [1] 131:8</p> <p>Laing [17] 1:9 81:14 105:3,16 106:22 116:23 123:24 125:14 131:17 135:8,17 147:3 149:4,25 151:13,19 328:15</p> <p>Laing's [3] 132:17 134:10 149:16</p> <p>large [8] 55:11 98:11 173:1 231:2 314:20 316:19 323:21 368:3</p> <p>larger [2] 106:18 169:7</p> <p>last [9] 80:21 81:24 84:4 110:2 152:12 153:17 169:11 313:7 324:9</p> <p>Lastly [1] 324:6</p> <p>late [10] 110:3 195:5 223:9,11 233:10 238:14 293:24 344:25 364:2 376:4</p> <p>lawyer's [1] 261:20</p> <p>lawyers [2] 224:11 374:13</p> <p>lay [2] 243:6 352:11</p> <p>layout [1] 117:11</p> <p>layperson [2] 51:20 231:16</p> <p>lead [3] 21:6 204:22 208:9</p> <p>leader [1] 337:12</p> <p>leadership [3] 19:20 59:23 296:13</p> <p>leading [1] 74:18</p> <p>leap [1] 20:13</p> <p>learn [15] 5:23 6:2 8:10 23:17,22 60:11,18 61:2 61:18,25 63:15 352:10 353:20,22 354:1</p> <p>learned [14] 19:1 20:23 22:25 42:8 136:18 177:23 229:1 244:13,16 245:16 317:5,11 352:19 365:22</p> <p>learning [3] 9:12 194:13 360:7</p> <p>least [5] 49:2 51:9 75:4 123:4 159:3</p> <p>leave [3] 218:24 239:11 355:14</p> <p>leaves [2] 216:11 223:17</p> <p>lecture [2] 12:12 196:12</p> <p>lectures [1] 13:9</p> <p>left [13] 16:12 45:13,21 58:12 157:5 189:20 196:17 208:17 218:18 219:9 229:20 299:1 327:21</p> <p>left-hand [2] 164:11,12</p> <p>legacy [2] 364:8,17</p> <p>legal [2] 362:5,14</p>	<p>lengthy [1] 17:3</p> <p>Les [2] 45:21 278:8</p> <p>less [19] 92:13 96:6,12,17 107:23 109:10 120:20 134:19 137:18 138:25 169:18,24 216:6 257:17 273:11 287:24 302:25 318:8 365:6</p> <p>lessor [1] 77:24</p> <p>letter [10] 31:8,9,14 61:12 64:6 65:2 191:4 192:14 244:8 246:12</p> <p>letters [1] 73:15</p> <p>level [14] 10:10 20:22 46:13,15 208:1 226:5,7 310:5 322:21 323:22 327:6 339:1,25 345:8</p> <p>levels [1] 214:8</p> <p>liability [2] 326:23,25</p> <p>liaisoning [2] 362:4 374:13</p> <p>licensing [1] 21:19</p> <p>life [1] 320:11</p> <p>light [1] 140:5</p> <p>likely [1] 87:9</p> <p>limit [1] 247:13</p> <p>limitation [1] 69:1</p> <p>limitations [4] 68:15 246:15 247:7,10</p> <p>limited [2] 217:14 248:2</p> <p>limits [1] 159:20</p> <p>line [31] 15:3 31:13 44:5 123:18 124:20,21 125:12 131:2,10 134:13,14,18 134:20,21,21,23,25 135:3 192:20 203:19 205:22 206:19,21 207:6 209:2 281:12 282:4 292:9 320:12 329:8 332:6</p> <p>lines [7] 17:8 18:1 193:6 239:18 265:7 276:7 328:19</p> <p>lingo [1] 142:2</p> <p>linkages [1] 225:4</p> <p>linked [8] 356:25 358:7 358:11 360:6 361:17 370:3,3,5</p> <p>linking [1] 362:14</p> <p>LIS [2] 152:17 154:2</p> <p>list [32] 3:2 69:16 93:1,7 93:19 94:12 95:12,19,20 96:18,19 100:4,6 105:12 105:14 106:16,18 116:8 131:17 132:13 135:16 138:9 142:22 148:9 156:10 159:23 187:17 199:12 328:17 335:6,8,9</p> <p>listed [3] 36:21 37:20 328:23</p> <p>listen [2] 80:14 101:11</p> <p>lists [9] 105:5,18 116:25 123:23 124:4 134:10 147:2 151:20 357:11</p> <p>literally [1] 240:7</p> <p>literature [6] 40:16</p>	<p>102:7,8,12 103:18 116:4</p> <p>litres [2] 50:14,15</p> <p>live [2] 23:23,23</p> <p>lives [1] 325:5</p> <p>living [4] 112:23 113:11 149:9 150:18</p> <p>locate [4] 25:20 123:22 125:13 332:1</p> <p>located [2] 369:17 370:12</p> <p>location [3] 197:4 287:21 369:7</p> <p>log [1] 91:21</p> <p>logged [1] 267:3</p> <p>longer [4] 135:7 204:19 290:24,25</p> <p>look [46] 17:10 27:23 28:6 29:7 32:25 44:15 44:25 59:5 63:22 91:8 98:15 104:4,9 115:18 137:11 157:18 160:21 161:7,12 170:22 171:12 171:13,15,19 172:12,13 178:11 235:23 239:12 257:23 266:10 267:6 268:9 281:15 282:21 285:11 287:19 288:16 290:21 291:19 321:7,23 329:4 332:6 357:10 366:5</p> <p>looked [11] 128:15 214:17 244:7,10 259:2 282:9 297:21 300:22 305:10 308:12 315:2</p> <p>looking [31] 5:13 28:24 63:8 64:20,20 76:18 143:25 147:2 160:6 162:2 167:1 169:22 171:4,23 172:4,25 200:17 204:15 204:20,21 219:14 226:8 232:19 247:3 252:16 281:12 285:5 294:3 299:20 320:1,12</p> <p>looks [5] 192:13 259:10 260:3 289:18 299:3</p> <p>loop [1] 65:25</p> <p>lose [1] 287:25</p> <p>loss [1] 367:16</p> <p>lost [1] 335:10</p> <p>lots [1] 285:12</p> <p>low [4] 165:9 171:7 175:23 331:12</p> <p>lumpectomy [1] 318:6</p> <p>lunch [3] 224:17,21 228:8</p> <p>luncheon [1] 224:8</p> <p>lung [1] 180:3</p> <p>luxury [4] 315:9 322:14 322:16,17</p>	<p>Madam [2] 312:25 337:19</p> <p>magnitude [1] 335:18</p> <p>main [6] 81:20,22 104:25 105:1 130:1 273:18</p> <p>mainframe [1] 30:18</p> <p>maintain [1] 187:14</p> <p>maintenance [1] 8:21</p> <p>Majesty [1] 1:8</p> <p>major [2] 312:22 321:8</p> <p>majority [2] 222:2 364:10</p> <p>makes [1] 26:23</p> <p>man [1] 320:19</p> <p>management [47] 10:13 19:2,19 21:5 42:20 44:6 53:21 55:2,22,23 58:2 321:16 349:11,12 350:24 351:7,9,11,23,25,25 352:2,5,12,14,23 353:9 354:1,17,20,23,24 355:25 356:24 357:24 360:3,4 370:19 371:4,12,13,23 373:13,19,21 375:8,18</p> <p>manager [74] 10:17 11:23 14:10,18,19 15:4 15:9,18 16:16,18 23:16 38:25 42:20 43:4,14,24 46:10,18 48:3 49:2,10 51:11 62:6 66:25 186:6 189:1,25 200:6 201:22 202:18 203:4,8,16,17,21 204:3,5 213:10 221:18 222:3,14,19 253:24 262:1 278:11,15 279:1,15 280:16 309:23 327:25 334:25 335:20 349:5,10 359:12 361:9,13,21 362:7 362:9,15 370:11,15 371:7 372:12,13,16,18,20 373:5 373:18 374:2,5</p> <p>manager's [2] 10:10 62:9</p> <p>managerial [1] 280:1</p> <p>managers [1] 321:15</p> <p>managing [2] 181:25 279:17</p> <p>mandate [1] 326:19</p> <p>mandatory [1] 262:8</p> <p>manner [2] 315:13 337:21</p> <p>manual [6] 228:11 233:24 235:14 256:20 304:9 350:16</p> <p>manually [2] 227:6 366:12</p> <p>manuals [2] 73:17 309:7</p> <p>manufacturer [3] 6:9 237:23 310:9</p> <p>manufacturing [1] 355:10</p> <p>March [11] 167:10,18 168:9 174:15,17 191:5,7 191:8 217:20 222:24 274:21</p> <p>Margaret [1] 377:6</p>
-L-				
-M-				

Inquiry on Hormone Receptor Testing

<p>Mark [3] 1:14 117:5 133:25</p> <p>marked [31] 234:12 239:19 259:13 285:6 310:10,13 347:13,14,15 347:16,17,18,19,20,21 347:22,23,24,25 348:1,2 348:3,4,5,6,7,8,9,10,11 348:12</p> <p>markers [2] 197:22 257:21</p> <p>marketplace [1] 294:3</p> <p>markings [1] 238:3</p> <p>Mary [17] 12:12,19 24:19 154:12 186:19 196:5 198:8 199:2 208:6 218:19 219:13 260:3,4 277:24 278:15 341:19 342:14</p> <p>mashing [1] 228:6</p> <p>mass [1] 88:12</p> <p>Masters [4] 351:1 359:14 359:19,20</p> <p>material [4] 12:10 269:11 282:12 291:2</p> <p>math [1] 297:23</p> <p>matter [7] 79:13 267:20 273:9 297:22 305:15,16 377:3</p> <p>matters [1] 294:18</p> <p>may [40] 5:7 36:15,25 45:4,4 53:7 57:15 59:2,5 71:8 90:7 96:12 106:12 119:11 134:4 148:24,24 165:8 175:24 177:20 204:17,17 232:11 240:3 244:13 249:21 257:24 274:8 286:8 287:25 301:24 307:16 322:1 324:10 328:11 339:24 355:6 359:8 366:5,9</p> <p>McCarthy [2] 81:15 127:8</p> <p>mean [97] 14:14 19:22 19:24 23:15 26:9 27:11 28:11 40:20 41:24 43:9 44:9,12 51:14,21 55:15 58:3 62:6 64:1 65:2 66:20 69:7 71:8 74:11 74:13,16 79:13 89:14 92:7 94:14 96:6 113:4 125:25 126:4,18,25 130:8 131:6 138:2 140:1,3 143:25 151:13 167:25 170:7 172:21 173:4 176:17,17,24 181:2 183:4 185:9,10 189:19,19,21 192:16 194:16 195:20 196:1 198:7 199:9 200:2 202:2 203:10,21,23 207:21 211:15 212:3 213:19 217:23 227:20 231:11 236:23 239:23 240:23 245:11 263:7 266:23 271:14 274:16 283:2 289:12 302:8,18 308:6 309:8 311:15 315:7 317:4 318:2 340:19 349:17 352:11 361:11 362:24</p>	<p>meaning [3] 227:10 289:20 300:11</p> <p>means [11] 38:16 42:9 47:4 93:23 239:12 247:23 263:9 276:23 330:19 357:16 377:10</p> <p>meant [5] 121:4 207:2 235:13 240:7 318:5</p> <p>measure [5] 7:24 8:3,5 50:23 353:18</p> <p>measured [1] 51:1</p> <p>measurement [1] 179:13</p> <p>measuring [1] 49:15</p> <p>mechanically [1] 139:21</p> <p>mechanics [2] 74:22 154:1</p> <p>mechanism [1] 366:17</p> <p>med [1] 314:22</p> <p>media [1] 19:17</p> <p>medical [13] 1:14 8:11 9:7 13:14 214:20 215:8 215:21 216:4 220:25 221:1 348:23 350:11 363:23</p> <p>medication [1] 367:14</p> <p>medicine [27] 28:22 43:15 52:13 67:16 68:10 68:20 76:20 90:10 91:7 94:22 102:2 112:25 114:23 115:9,23 138:20 159:11,16 188:9,10 309:13 321:1,24 334:7 337:7 358:3 368:9</p> <p>Meditech [33] 22:13 23:7,15,18 24:2,7 26:12 26:14,16 27:1,13,18,20 27:23 28:11,12,16,17,20 28:25 29:15 30:6,7,10 30:11,14 106:13 152:17 154:2 155:2,21 303:17 303:22</p> <p>meet [2] 267:13 318:15</p> <p>meeting [21] 37:5,23 39:24 40:2,2,4,11 41:10 69:23 70:5,8,15,20 71:1 71:3 128:8 153:2,7 162:15 292:17 294:10</p> <p>meetings [17] 35:2,9,11 35:16,21 36:8 40:9 70:22 74:11,12,12,12 81:3,6 81:12,14 195:9</p> <p>members [2] 1:12 178:8</p> <p>memo [17] 17:7,23 18:11 32:10 60:6,7,12 62:21 64:14 66:8,20,21 67:4 69:15 287:5,6 292:23</p> <p>memorandum [3] 285:9 291:14,15</p> <p>Memorial [2] 121:8 348:18</p> <p>memos [4] 59:2 66:12 66:16 285:5</p> <p>mental [1] 364:15</p> <p>mention [1] 291:17</p> <p>mentioned [21] 4:21</p>	<p>7:17 10:12,25 13:1,23 18:4,21 25:3 34:17 53:25 103:22 143:20 166:8 171:11 196:19 197:23 223:20 230:21 235:3 296:25</p> <p>mentioning [1] 85:4</p> <p>mentions [4] 5:16 31:15 31:15 238:9</p> <p>merged [1] 371:4</p> <p>message [5] 84:10 328:9 328:13 365:14 366:1</p> <p>met [14] 4:8 55:16 57:12 178:7 189:12 267:15,23 270:15,18 286:22 292:22 324:9 329:16 330:24</p> <p>meters [1] 9:23</p> <p>method [17] 34:6 197:13 225:3,14 226:19 228:9 228:11 230:14,23,24 232:14,14 233:11 240:16 268:25 269:4,9</p> <p>methodology [7] 233:25 235:16 269:14,15 270:3 273:13 315:24</p> <p>methods [1] 225:20</p> <p>metric [2] 271:23 274:9</p> <p>microbiology [2] 9:10 52:15</p> <p>microscope [3] 61:5 225:7 334:13</p> <p>microwave [3] 229:3 230:22 232:14</p> <p>might [42] 23:19 24:17 35:12 57:15 73:19 76:18 77:2 83:10,12 92:16 103:1 109:11 127:25 135:22 139:16,19,20 159:15 180:3,3,4 185:19 208:16 214:17 216:15 219:1 232:16 242:10 249:25 250:8 251:2 282:16 291:25 306:3 308:4,9,10 312:14 315:9 339:21 346:13 349:17</p> <p>million [1] 334:18</p> <p>mind [7] 75:22 80:21 112:20 137:3 140:19,20 140:20</p> <p>mine [3] 153:13 335:9,11</p> <p>minimizing [1] 312:17</p> <p>minus [1] 169:20</p> <p>minute [1] 37:1</p> <p>minutes [7] 36:12 38:9 38:24 241:25 242:14 243:1 344:10</p> <p>mis-call [1] 92:11</p> <p>misinterpretation [2] 92:24 96:14</p> <p>misinterpreted [1] 104:18</p> <p>misread [1] 104:13</p> <p>missed [2] 39:7 204:18</p> <p>missing [3] 137:14 321:19,21</p> <p>misunderstood [1]</p>	<p>128:11</p> <p>mixed [2] 49:5 50:16</p> <p>mixing [1] 49:9</p> <p>mixture [2] 49:25 50:1</p> <p>mode [3] 354:7,11,14</p> <p>moment [3] 38:3 177:18 259:14</p> <p>money [7] 187:18 199:23 233:5 255:1 290:17 314:8 316:8</p> <p>monitor [1] 357:7</p> <p>monitored [1] 357:8</p> <p>monitoring [1] 248:1</p> <p>monobasic [1] 50:9</p> <p>month [3] 56:24 208:13 300:5</p> <p>months [11] 23:19,20 167:6,21 169:12,16 172:23 195:3 221:25 325:4 334:3</p> <p>Montreal [1] 89:13</p> <p>morning [10] 4:5,10 72:17,19 133:14,19 135:8 147:5 300:23 376:8</p> <p>Moss [2] 377:2,13</p> <p>most [27] 20:2 21:16 27:14 28:6 40:14 46:10 47:13 67:24 68:22 69:21 137:15 154:6 156:6 199:9 225:15 239:8 256:17,17 258:2 265:14,16,17 303:8 304:8 312:21 321:8,13</p> <p>mostly [6] 12:23 19:3 85:13 154:6 252:15 263:3</p> <p>Mount [44] 7:23 84:20 85:22 87:17 90:13 92:4 105:19 117:10,10,18 121:2 131:4 134:15 135:2 135:5 152:15 154:16 157:5,15 163:2 172:7,15 173:24 266:23 269:12 270:23 272:14 273:1,5,6 273:15,21,24 282:9 306:21 307:11 310:25 313:15 318:16 322:8 329:3,4 330:25 331:11</p> <p>mouse [4] 38:16 205:25 291:20 339:8</p> <p>move [14] 4:15,20 38:23 52:23,24 54:5,12 55:19 57:16 58:3 205:23 206:18 359:11 361:21</p> <p>moved [12] 18:9 45:21 51:22 53:7,8 56:12 184:22 278:8,23 290:11 370:15 371:25</p> <p>moves [2] 278:4,6</p> <p>moving [10] 33:14 197:4 290:2 293:18 315:13,24 356:7,8 357:4 361:12</p> <p>Ms [468] 2:8 4:13,21 5:14 7:17 12:1,1 22:11 23:1 31:7 32:25 34:11,18 42:18 43:1 45:13,17,21 51:6 58:4 60:7 63:13 64:7 70:6 72:9,15,16,20 73:22 74:8,20 75:1,10</p>	<p>75:15,19 76:8,16,23 77:10 78:10,18 79:1,8 79:15 80:19 81:2,11,19 81:23 82:17 84:1,6,8 85:8,19,24 86:4,17,22 87:12,18,25 88:8,15,21 89:3,9,16,22 90:1,7,8,17 90:21,25 91:4,14,19 92:6 92:14,25 93:5,11,16,21 93:22 94:3,10,20 95:5 95:11,17,24 96:19,23 97:4,9,15,19 98:5,10,22 99:3,21 100:3,11,21 101:2,16,20,23,24 102:9 102:22 103:7,11,15 104:3 104:14,21 105:2,11,24 106:3,16,17 107:3,11,15 107:20 108:3,7,13,18,24 109:3,8,17 110:1,2,12 110:17,21,25 111:9,14 111:21 112:5,14,18 113:5 113:9,15,24 114:9,21 115:1,5,13,20 116:6,13 116:18,22 117:15,22 118:2,6,12,23 119:8,12 119:17 120:1,6,19 121:15 121:19 122:1,5,10,14,20 123:3,8,13 124:2,7,15 124:19 125:2,8,17,22 126:2,14,19 127:2,7,19 127:23 128:5,10,18,23 129:10,14,19 130:2,9,15 130:20,24 131:9 132:1,7 132:11,21 133:1,6,13,15 133:22,23 134:8 136:4,8 136:14,21 137:1,9,23 138:5,12,15,18 139:9,15 139:16 140:4,18,19 141:3 141:8,13,22 142:4,14,21 143:1,9,14,19 144:8,12 144:16,20 145:2,8,14,18 145:22 146:2,6,10,15,17 146:21 147:1,10,16,25 148:7,13,18 149:3,18,23 150:6,16 151:3,9,17 152:2 153:8,25 154:8,19 154:24 155:6,11,15,20 156:2,7,11,15,19,25 157:7,12,23 158:4,8,14 159:1,9,19 160:2,14 161:5,14,15,21 162:4,9 162:17,21 163:6,10,16 163:21 164:3,8,19,24 165:3,12,19,24 166:6,15 166:20,25 167:7,11,15 167:22 168:7,12,21,25 169:6,13,21 170:3,11,16 171:3,16,22 172:3,11,18 172:24 173:8,15,25 174:4 174:9,19,23 175:3,8,13 175:17 176:1,20 177:1,9 177:20,23 223:11 228:21 235:5 260:6,12 261:21 278:5 286:19 290:25 299:25 302:24 317:7 328:8,14 338:3 344:25 345:8,13,17,22 346:2,3 346:7 348:14,17 349:19 350:2,10,21 351:8,13,17 351:21 352:6,13,18,24 354:13,21 355:19 356:1 356:9,15,20 357:19 358:5 358:10,15,22 359:1,7,15</p>
---	--	---	---	---

<p>359:21,25 360:5,15,23 361:4,8,16 362:8,12,19 363:2,14,19 364:5 365:2 365:8 366:10 367:5,11 367:23 368:18 369:11,18 370:13,21 371:1,17,21 372:6,11,22 373:2,8,14 373:20 374:6,17,21,25 375:4,11,19 376:2</p> <p>MSH [1] 266:22</p> <p>Mullen [2] 282:8 283:7</p> <p>multiple [14] 19:8 20:17 56:11,11 67:8,11 74:17 139:7,11 176:25 242:21 242:24 282:25 310:4</p> <p>multiply [1] 200:20</p> <p>Murphy [2] 16:18 46:11</p> <p>must [11] 39:7 124:24 198:21 255:15 266:23 268:11,17,20 311:9 323:25 336:21</p>	<p>256:8,11,16,18,25 257:3 257:10,17,22 258:3,6,13 258:14,18 259:19 260:18 261:3,5,7 262:7,12,18 263:6 264:14,25 265:5 265:25 267:5,5 269:6,25 274:1 282:11,19 283:12 283:15 284:22 298:5,9 298:17 299:5,9,13 303:9 307:20 308:25 330:10,16 332:8,20 333:6 335:14</p> <p>negative/negative [1] 333:15</p> <p>negative/PR [1] 112:8</p> <p>negatives [12] 80:6,18 166:11 170:8 171:21 173:6 175:21 266:9 312:19,20,21 329:17</p> <p>neither [1] 105:13</p> <p>NEQAS [1] 213:3</p> <p>neutral [1] 50:19</p> <p>never [20] 17:13 61:22 74:25 75:2 79:24 127:11 159:2 201:10,10 231:25 232:13 236:24 267:15 270:15,18 281:19 282:24 310:18 335:18 355:6</p> <p>new [53] 13:11 24:10 31:24 32:2,7,18 33:20 33:24 34:10 62:25 76:10 110:7 131:18 152:15,17 152:18 153:15,19 154:14 154:15 155:14 187:16 190:1,8,9,11,15,19 194:16,17,18,21 196:9 199:12 214:4 228:11 244:16 289:15,20 290:4 290:15,15,21 294:3 300:2 314:16,20 315:13 317:3 318:1 336:19 346:10 368:19</p> <p>Newbury [337] 1:15 2:4 72:9,15,16,20,21 73:22 74:8,20 75:1,10,15,19 76:8,16,23 77:10 78:10 78:18 79:1,8,15 80:19 81:2,11,19,23 82:17 84:1 84:7,8 85:8,19,24 86:4 86:17,22 87:12,18,25 88:8,15,21 89:3,9,16,22 90:1,8,17,21,25 91:4,14 91:19 92:6,14,25 93:5 93:11,16,22 94:3,10,20 95:5,11,17,24 96:19,23 97:4,9,15,19 98:5,10,22 99:3,21 100:3,11,21 101:2,16,20,24 102:9,22 103:7,11,15 104:3,14,21 105:2,11,24 106:3,16,17 107:3,11,15,20 108:3,7 108:13,18,24 109:3,8,17 110:1,12,17,21,25 111:9 111:14,21 112:5,14,18 113:5,9,15,24 114:9,21 115:1,5,13,20 116:6,13 116:22 117:15,22 118:2 118:6,12,23 119:8,12,17 120:1,6,19 121:15,19 122:1,5,10,14,20 123:3 123:8,13 124:2,7,15,19 125:2,8,17,22 126:2,14</p>	<p>126:19 127:2,7,19,23 128:5,10,18,23 129:10 129:14,19 130:2,9,15,20 130:24 131:9 132:1,11 132:21 133:1,6,13,15,22 133:23 134:8 136:8,14 136:21 137:1,9,23 138:5 138:12,18 139:9,15 140:4 140:18 141:3,8,13,22 142:4,14,21 143:1,9,14 143:19 144:8,12,16,20 145:2,8,14,18,22 146:2 146:6,10,15,21 147:1,10 147:16,25 148:7,13,18 149:3,18,23 150:6,16 151:3,9,17 152:2 153:8 153:25 154:8,19,24 155:6 155:11,15,20 156:2,7,11 156:15,19,25 157:7,12 157:23 158:4,8,14 159:1 159:9,19 160:2,14 161:5 161:14,21 162:4,9,17 163:6,10,16,21 164:3,8 164:19,24 165:3,12,19 165:24 166:6,15,20,25 167:7,11,15,22 168:7,12 168:21,25 169:6,13,21 170:3,11,16 171:3,16,22 172:3,11,18,24 173:8,15 173:25 174:4,9,19,23 175:3,8,13,17 176:1,20 177:1,9 328:9</p> <p>Newfoundland [7] 63:17,18 72:22 273:20 274:4 377:8,11</p> <p>next [11] 14:1 39:23 58:11 237:22 243:3,4 278:7 286:8 288:10 345:1 345:15</p> <p>nine [7] 119:4 239:11,17 259:7,15 304:24 338:12</p> <p>NIST [3] 5:20 7:14 8:4</p> <p>NL [3] 1:8,14,15</p> <p>NLCHI [20] 91:1,3 117:24 118:1,10,14 119:23,25 158:23 160:19 160:25 163:14 176:11,12 176:18 298:23 299:1,15 302:18 312:24</p> <p>NLCHI's [1] 91:5</p> <p>nobody [4] 83:17 253:18 298:21 365:23</p> <p>noise [1] 243:10</p> <p>non [3] 163:22 164:4 365:15</p> <p>non-breast [2] 163:23 164:2</p> <p>none [1] 333:10</p> <p>nonetheless [1] 38:24</p> <p>nor [2] 105:13 189:20</p> <p>normal [1] 45:25</p> <p>normally [1] 192:21</p> <p>North [1] 256:17</p> <p>note [5] 86:23 227:6 274:21 276:4 285:8</p> <p>noted [3] 14:5 15:2 134:2</p> <p>notes [1] 177:19</p> <p>nothing [12] 22:6 80:20</p>	<p>110:13 156:14 180:19 181:22 274:4 276:20 293:6 294:22 317:19 320:18</p> <p>notice [1] 292:9</p> <p>noticeable [1] 14:17</p> <p>noticed [2] 224:10 308:11</p> <p>notion [14] 8:24 9:15 17:20 21:6 32:17,20 33:2 35:3 42:24 43:21 61:15 63:21 64:12 65:4</p> <p>notwithstanding [1] 171:25</p> <p>Nova [1] 278:6</p> <p>November [3] 3:1 86:8 86:9</p> <p>now [117] 5:13 6:20 9:20 11:6,23 22:11 23:12 25:2 28:5 31:16 32:23 34:16 35:1 36:1,20 38:23 39:4 39:20 40:24 42:18 52:22 57:25 58:2 59:1 67:21 68:7 77:1,23 78:4 80:12 85:1,3 87:8 90:24 92:11 92:17 93:17 96:15 97:10 97:20,21 100:4 104:1 107:23 109:10,16 110:4 111:15 112:23 114:6 116:5 121:16 123:14 129:5 130:4 131:1,15 132:13 136:15 138:22 158:23,25 159:10 160:12 161:3 169:7 172:12 179:15 180:18 195:13 197:6 209:9 211:9 219:2 221:18 226:4 228:2 232:18 233:19 236:21 237:16 246:19 258:2 261:6 263:25 274:21 275:24 283:18 285:8 296:24 297:17 299:10 302:14 304:19 309:6 310:7 314:16 315:4,5,6 316:6 317:13 324:23 325:16,19 331:17 332:5 333:20 334:14,15 335:23 345:13 349:13 355:15,22 372:1 373:11</p> <p>nowhere [1] 267:18</p> <p>NTV [1] 300:1</p> <p>nuances [1] 355:8</p> <p>nuclear [1] 104:19</p> <p>number [67] 4:6 5:16 20:3 21:25 24:25 35:2,6 35:15 39:7,8 41:14,15 44:17,21 51:6 59:9 77:25 84:11 89:2 91:24 92:6 96:4 98:16 100:7 105:10 107:19 109:10 110:22 111:1,12,15,19,20,22 114:5 117:8 130:25 135:20 140:15 141:4 144:6 147:5,6,23 148:15 151:16,18,23 154:15 175:23 179:23 180:13 183:16 186:23 200:21,24 300:24 301:14,15 302:8 302:9,13 328:10 329:8 341:6 346:10,13</p>	<p>numbering [2] 87:1 230:17</p> <p>numbers [32] 86:11,19 88:4,17,20,25 89:5,15 96:21 115:24 119:3 121:24 125:5 135:6,22 140:5 143:22,25 144:2 151:8,11 163:15 170:7 170:10 175:21 266:6 269:18 297:23 301:7 329:6,6 331:13</p> <p>numerous [1] 227:4</p> <p>nurse [3] 348:20,22 349:18</p> <p>nursing [4] 348:19 350:25 359:19 360:11</p>
<p>-N-</p>				
<p>n [4] 207:17,17 213:25,25</p> <p>Naghibi [1] 274:22</p> <p>name [4] 84:16 329:5 345:21 370:25</p> <p>named [2] 117:3 230:3</p> <p>names [2] 30:20 335:8</p> <p>Nancy [1] 359:3</p> <p>national [11] 4:24 5:3,5 5:8 9:1 13:6,25 18:24 20:14,22 22:3</p> <p>nature [1] 296:4</p> <p>necessarily [4] 60:5 190:4 249:16 349:22</p> <p>necessary [5] 9:15 49:7 59:6 288:17 289:19</p> <p>need [19] 30:10 32:2 37:8 73:5 103:23 141:16,20 142:2,8 144:19 201:7 251:14 268:6 287:22 290:20 310:16 316:25 328:17 332:5</p> <p>needed [5] 46:25 280:12 280:14,22 318:17</p> <p>needs [7] 7:1 33:24 46:16 113:11 207:20 268:7 361:25</p> <p>negative [128] 34:20,21 34:24 35:1 37:9 41:2,17 42:1,9 80:13 82:4 85:2 87:3 88:7 92:12,18 96:16 98:12,13 100:23 101:5 108:16,17 111:25 112:10 113:19 114:7 115:7 117:18 123:21 124:11 126:6,25 131:2,11,13,25 132:3,15 137:19 141:5 145:9,13 164:10,15,16 164:21 165:14,15,21 168:19 171:2 173:13,13 173:22,23 234:1 235:17 250:21 251:3,12,18,22 251:24 252:5,18,19 253:10,19 254:1,11,16 254:22,25 255:10,15</p>	<p>n [4] 207:17,17 213:25,25</p> <p>Naghibi [1] 274:22</p> <p>name [4] 84:16 329:5 345:21 370:25</p> <p>named [2] 117:3 230:3</p> <p>names [2] 30:20 335:8</p> <p>Nancy [1] 359:3</p> <p>national [11] 4:24 5:3,5 5:8 9:1 13:6,25 18:24 20:14,22 22:3</p> <p>nature [1] 296:4</p> <p>necessarily [4] 60:5 190:4 249:16 349:22</p> <p>necessary [5] 9:15 49:7 59:6 288:17 289:19</p> <p>need [19] 30:10 32:2 37:8 73:5 103:23 141:16,20 142:2,8 144:19 201:7 251:14 268:6 287:22 290:20 310:16 316:25 328:17 332:5</p> <p>needed [5] 46:25 280:12 280:14,22 318:17</p> <p>needs [7] 7:1 33:24 46:16 113:11 207:20 268:7 361:25</p> <p>negative [128] 34:20,21 34:24 35:1 37:9 41:2,17 42:1,9 80:13 82:4 85:2 87:3 88:7 92:12,18 96:16 98:12,13 100:23 101:5 108:16,17 111:25 112:10 113:19 114:7 115:7 117:18 123:21 124:11 126:6,25 131:2,11,13,25 132:3,15 137:19 141:5 145:9,13 164:10,15,16 164:21 165:14,15,21 168:19 171:2 173:13,13 173:22,23 234:1 235:17 250:21 251:3,12,18,22 251:24 252:5,18,19 253:10,19 254:1,11,16 254:22,25 255:10,15</p>	<p>next [11] 14:1 39:23 58:11 237:22 243:3,4 278:7 286:8 288:10 345:1 345:15</p> <p>nine [7] 119:4 239:11,17 259:7,15 304:24 338:12</p> <p>NIST [3] 5:20 7:14 8:4</p> <p>NL [3] 1:8,14,15</p> <p>NLCHI [20] 91:1,3 117:24 118:1,10,14 119:23,25 158:23 160:19 160:25 163:14 176:11,12 176:18 298:23 299:1,15 302:18 312:24</p> <p>NLCHI's [1] 91:5</p> <p>nobody [4] 83:17 253:18 298:21 365:23</p> <p>noise [1] 243:10</p> <p>non [3] 163:22 164:4 365:15</p> <p>non-breast [2] 163:23 164:2</p> <p>none [1] 333:10</p> <p>nonetheless [1] 38:24</p> <p>nor [2] 105:13 189:20</p> <p>normal [1] 45:25</p> <p>normally [1] 192:21</p> <p>North [1] 256:17</p> <p>note [5] 86:23 227:6 274:21 276:4 285:8</p> <p>noted [3] 14:5 15:2 134:2</p> <p>notes [1] 177:19</p> <p>nothing [12] 22:6 80:20</p>	<p>nowhere [1] 267:18</p> <p>NTV [1] 300:1</p> <p>nuances [1] 355:8</p> <p>nuclear [1] 104:19</p> <p>number [67] 4:6 5:16 20:3 21:25 24:25 35:2,6 35:15 39:7,8 41:14,15 44:17,21 51:6 59:9 77:25 84:11 89:2 91:24 92:6 96:4 98:16 100:7 105:10 107:19 109:10 110:22 111:1,12,15,19,20,22 114:5 117:8 130:25 135:20 140:15 141:4 144:6 147:5,6,23 148:15 151:16,18,23 154:15 175:23 179:23 180:13 183:16 186:23 200:21,24 300:24 301:14,15 302:8 302:9,13 328:10 329:8 341:6 346:10,13</p>	<p style="text-align: center;">-O-</p> <p>o [5] 207:17,17,17 213:25 223:20</p> <p>O'Malley [2] 275:25 278:13</p> <p>objective [5] 189:11 317:18,22 318:13,18</p> <p>objectives [1] 357:3</p> <p>obliged [1] 327:10</p> <p>obscure [1] 225:4</p> <p>obstacle [1] 316:3</p> <p>obtained [1] 90:12</p> <p>obvious [2] 259:17 269:13</p> <p>obviously [13] 18:10 20:2 46:23 55:15,20 187:13 235:6 244:1 274:17 292:1 312:20 317:5 318:19</p> <p>occasion [2] 34:18 235:8</p> <p>occasions [1] 20:22</p> <p>occur [4] 35:7 53:13 55:13 150:25</p> <p>occurred [5] 42:6,10 48:9 67:6 69:25</p> <p>occurrence [12] 354:3 361:19,22 363:4 364:12 365:12,14,22 366:15,18 367:25 369:6</p> <p>occurrences [5] 362:18 366:25 367:13,15 368:6</p> <p>occurring [4] 17:22 49:3 55:12 69:2</p> <p>October [25] 1:4 77:15 84:10,14 110:4 204:15 221:19 222:11,18,22,24 232:23 266:18 273:3 300:1,16 301:13 313:6 316:14 372:7,9,9 375:12 377:5,12</p> <p>odds [1] 41:18</p> <p>off [31] 9:6 35:20,22 39:14 40:6 41:1,22 79:17 83:24 85:17 87:14 88:19 88:25 109:24 111:12 119:4 122:6 140:16 142:7 143:5 150:23 154:17 186:14 199:25 239:19 240:17 243:2 299:6 311:8</p>

<p>351:24 352:25 offer [1] 137:19 offered [7] 23:11 73:9 79:7 80:16 308:4 324:15 351:16 offhand [1] 36:1 office [8] 62:20 261:20 292:22 369:20,22,22 370:9,15 officer [1] 70:7 offices [1] 369:21 official [9] 92:4 111:15 111:19,20 284:8,16,17 299:12 319:3 officially [1] 215:16 officials [1] 81:7 offs [1] 299:21 often [1] 154:6 old [12] 31:20,25 32:7,18 33:20,20 34:11 71:18 190:2 228:10 335:11 375:14 on-site [2] 56:2,14 once [12] 7:9 51:12 57:4 57:5,11 82:18 101:3 116:17 124:25 152:13 153:11 161:1 oncologist [15] 78:25 81:15 113:23 114:1,3 129:4 138:24 181:24 182:8,18 184:1,17 308:11 328:16 334:25 oncologists [24] 41:23 80:14 81:7 100:2,13,19 101:10 112:20 126:12 127:6 128:9,20 132:8,23 136:3 149:11 150:5,11 151:13 152:21 153:20 183:2 265:24 336:14 one [132] 12:15 13:13,19 17:13 22:25 26:2 27:5,7 27:9,9 28:19 29:4,11 30:7 31:24 32:3 33:19 33:25 35:17 38:19 40:2 40:20 47:23 50:17,18 51:17,17,22 52:1,14,17 53:7,25 54:11 55:24 56:12,21 70:24 71:16 78:8 83:10 84:6,12,24 93:14 96:4,17 99:15 123:20 124:16 125:1,18 126:13 131:10,13 133:7 134:19 135:9,11 144:5 145:25 148:3,5,6 160:3 162:1 168:1,5 175:4,6 176:2,7,24 177:5,18 185:19 204:18 205:25 214:21 223:21 239:11,17 248:8 250:8 251:1,4 255:7 259:2 266:1 272:24 274:17 276:7 279:25 285:10,13,14 286:8,9,11 287:4,4,7,10,20 290:10 299:17,19 300:2,6 306:14 308:9,10 310:20,25 324:7 328:6,8 329:14 330:9 331:23 332:7 338:6 339:9 341:16,21 342:25 355:7 357:4 358:3 367:25</p>	<p>368:24 370:7 one-year [1] 355:24 ones [16] 63:18 69:12,12 88:19 137:10 143:24 146:1 165:6 168:17 173:5 190:2 245:6 266:8 272:21 289:21 303:8 ongoing [2] 53:4 90:20 Ontario [2] 19:5 311:2 onto [1] 359:12 open [1] 324:22 operate [2] 28:13 30:14 operating [7] 290:18 309:7 310:22 338:11,17 340:22 343:5 operation [1] 58:14 operation's [1] 316:8 operations [8] 14:14 28:25 29:13 46:13,15 55:24 199:24 200:1 opinion [19] 71:1 78:25 79:2 138:3,4 150:15 161:20,22 162:5 191:16 246:3,8 283:4 284:3,7 296:12 317:12 323:2 334:8 opportunity [8] 61:1 159:12 308:3 325:13 326:8 327:6 333:25 337:20 opposed [5] 22:21 61:7 149:9 200:3 233:15 opposite [1] 85:2 optimal [2] 344:2 365:7 optimizing [1] 33:3 oral [3] 293:11 294:6,13 order [11] 53:9 59:18 183:13 189:3 200:8 232:6 255:1 304:16 316:8,9 331:18 ordered [3] 303:22,25 306:6 ordering [3] 10:1,4 46:6 organization [10] 6:20 18:23,24 20:18 30:9 203:24 315:16,21 325:17 368:4 organizational [1] 246:24 organizations [3] 20:2 56:11 364:17 organize [2] 95:2 335:7 organized [4] 88:24 117:23 123:5 335:23 organizing [2] 62:18 63:23 orientation [1] 106:24 origin [2] 118:21 302:1 original [37] 52:1 78:1 84:12,18,21,23 94:18 104:18 105:6,18 106:14 109:20,22 117:9,9,17 118:21 121:12 122:25 134:14 136:12 137:14 141:2 152:16,18 156:4</p>	<p>157:15 158:2 307:7 329:2 329:3,15 330:9 331:19 332:8,8,9 originally [19] 52:11 77:18 80:11,15 83:1 85:1 87:1 92:7,8,11 103:25 108:23 115:6 141:2 142:12 150:13 158:19 266:22 370:2 originated [1] 119:1 Oscar [1] 84:11 otherwise [3] 308:4 342:13 366:8 Ottawa [3] 19:16 56:20 56:25 ought [1] 136:10 out-call [1] 56:13 outcome [4] 119:25 188:20 190:12 274:18 outcomes [1] 271:25 outline [3] 61:23 198:12 228:19 outlines [2] 66:22 290:9 output [4] 188:2,20 189:3 201:20 outset [3] 114:17 244:13 245:19 outside [6] 63:17 67:9 75:12 170:9 275:16 308:9 oven [2] 230:22 232:14 ovens [1] 229:3 overall [13] 13:12 58:19 178:12 183:4 187:12 188:13 193:2 196:17 267:6 284:5 288:24 295:20 314:16 oversaw [1] 321:16 oversee [1] 277:4 overseeing [1] 200:4 oversight [2] 277:12 280:1 overview [1] 166:2 own [24] 29:9 39:12,21 47:25 62:2 63:6 75:20 75:24 90:13 91:9,24 120:22 138:19 142:22 183:18 191:25 203:2 238:3 251:10 252:17 290:3 293:18 372:2,2</p>	<p>P-1889 [2] 31:6 191:1 P-2129 [1] 152:8 P-2155 [1] 64:9 P-2413 [1] 38:23 P-2642 [1] 106:20 P-2888 [1] 232:17 P-2939 [3] 3:3 346:14 347:13 P-2944 [3] 3:3 346:15 347:13 P-2948 [3] 3:4 346:15 347:14 P-2949 [3] 3:4 346:15 347:14 P-2951 [3] 3:5 346:15 347:15 P-2957 [3] 3:5 346:16 347:15 P-2960 [3] 3:6 346:16 347:16 P-2965 [3] 3:7 346:16 347:17 P-2973 [3] 3:7 346:17 347:17 P-2979 [3] 3:8 346:17 347:18 P-2981 [3] 3:8 346:18 347:18 P-2983 [3] 3:9 346:18 347:19 P-3003 [3] 3:9 346:18 347:19 P-3005 [3] 3:10 346:19 347:20 P-3029 [3] 3:10 346:19 347:20 P-3031 [3] 3:11 346:20 347:21 P-3035 [3] 3:11 346:20 347:21 P-3037 [3] 3:12 346:20 347:22 P-3040 [2] 3:13 347:23 P-3041 [3] 3:13 346:21 347:23 P-3043 [3] 3:14 346:21 347:24 P-3048 [3] 3:14 346:21 347:24 P-3049 [2] 346:22,22 P-3050 [1] 229:19 P-3052 [3] 3:15 346:23 347:25 P-3054 [3] 3:15 346:23 347:25 P-3056 [3] 3:16 346:23 348:1 P-3059 [2] 3:17 348:2 P-3073 [3] 3:17 346:24 348:2 P-3075 [3] 3:18 346:24 348:3 P-3078 [2] 3:19 348:4 P-3107 [2] 162:19 300:23</p>	<p>P-3113 [1] 67:6 P-3215 [1] 176:3 P-3370 [3] 3:20 346:25 348:5 P-3380 [3] 3:20 346:25 348:5 P-3381 [1] 3:28 P-3382 [2] 3:21 348:6 P-3385 [3] 3:21 347:1 348:6 P-3386 [1] 3:28 P-3387 [3] 3:22 347:1 348:7 P-3410 [3] 3:22 347:2 348:7 P-3411 [1] 3:28 P-3412 [1] 3:28 P-3413 [3] 3:23 347:2 348:8 P-3415 [3] 3:23 347:2 348:8 P-3416 [1] 3:28 P-3417 [2] 3:24 348:9 P-3418 [3] 3:24 347:3 348:9 P-3419 [1] 3:28 P-3420 [3] 3:25 347:3 348:10 P-3462 [3] 3:25 347:3 348:10 P-R-E-D-H-A-M [1] 345:23 page [58] 3:1 12:12 86:6 132:23 204:20,23 206:18 209:1 230:10,16,20,25 231:22 232:17 233:20 234:3 239:4,11,17 248:19 248:24 255:5,20 256:4 259:2,3,7,15,22 262:24 267:7 272:24 275:25 276:4,7,12 281:12 282:2 282:6,16 285:5,7,12 287:22 288:5 291:12,21 297:2,3 300:23 313:1 319:24 320:13,15 338:12 339:6,6,8 pages [4] 117:8 235:24 237:18 313:3 Pam [1] 375:7 panel [3] 112:2 114:13 150:20 panelled [1] 151:22 panels [1] 20:17 PAP [1] 13:21 paper [4] 137:11 235:1 285:6 304:25 paraffin [3] 39:10 47:18 318:4 paraffinized [3] 196:23 197:7,18 paragraph [16] 84:15 152:12 192:23 227:25 239:18 246:13,23 282:3 287:20,21,23 288:5,8,10 288:13 297:3</p>
--	--	---	--	---

<p>Parai [7] 216:20 217:5 217:12,24 218:5 219:24 221:13</p> <p>parallel [4] 32:3 33:4,7 33:24</p> <p>Pardon [2] 222:16 271:12</p> <p>pareto [1] 353:25</p> <p>Parks [3] 49:6 64:12,17</p> <p>Parsons [1] 359:3</p> <p>part [44] 13:8 19:11 24:3 26:3 71:24 87:22 90:12 90:13 92:3 99:11 154:13 164:1 190:15,23 197:3 199:17 202:9,20 206:2 207:9 211:25 213:22 218:3 225:18,24 226:18 237:21 240:19 244:10 245:2 249:1 251:12 253:16 260:16 278:8 286:24 287:17 288:24 290:13 298:23 315:25 338:14 340:21,24</p> <p>participate [1] 69:17</p> <p>participated [2] 67:8 69:16</p> <p>participation [3] 159:21 209:6 211:9</p> <p>particular [42] 5:19 10:6 23:18 49:2 67:22 70:20 77:13 82:21 86:13 99:8 102:1 105:5 106:5 107:22 115:14 124:9 125:25 139:12 156:14 173:18 176:4,14 183:5 188:10 196:3,5 198:20 211:7,25 239:21 251:25 257:25 320:24 321:3 324:21 326:24 328:13 331:10 337:9 342:2,18 366:4</p> <p>particularly [5] 99:13 153:13 159:15 171:6,7</p> <p>partly [1] 274:16</p> <p>parts [16] 20:24 25:24 28:22 38:9 54:12 67:24 69:7 163:14 201:3 242:20 280:11 289:24 314:23 321:24 336:20,23</p> <p>passage [1] 276:6</p> <p>passed [1] 12:10</p> <p>past [6] 19:15 20:8 116:20 269:11 334:3 337:8</p> <p>Pat [2] 81:16 176:7</p> <p>pathological [1] 26:1</p> <p>pathologist [49] 18:1 51:22 56:25 61:8 64:22 68:2 104:17 121:11 129:4 181:5 182:14,21 183:13 184:15 205:17,19,19 206:7 207:6,12 209:3 210:17 214:23 218:1,20 219:10,17 244:19 246:5 249:24 251:14 253:14 261:4,25 264:5 275:15 277:3 280:13 281:8 304:14 305:6,18 306:8 314:17 316:4,6 321:8,10</p>	<p>334:25</p> <p>pathologist's [3] 64:18 140:1 188:23</p> <p>pathologists [56] 15:11 17:14,17 18:7,9 25:17 36:10 37:5,7 39:12,15 39:20 41:19 52:4,21 56:3 56:13 57:23 59:10,12 65:24 66:20 81:8 93:10 119:6,7 123:9 140:2 152:14,21 157:19 160:9 160:9 180:2,19 182:16 188:18,20 190:10 194:15 196:4 209:8 211:21 250:3 253:25 261:3 262:21 275:11 285:14,18 286:9 304:7 317:15 321:11 335:21 337:16</p> <p>pathologists' [2] 261:10 311:24</p> <p>pathology [69] 9:9 10:20 10:22 14:15,21 16:16,19 25:8 27:15,20 28:23 29:6 43:9,11,19 44:1 46:14 46:14 51:15,19 52:17 53:10 54:12 55:10 56:12 57:15,17 58:6,10 68:1 82:9 84:22 119:5 187:9 187:15 188:10 196:3 199:25 204:8 211:20,25 213:20,23 222:19 230:5 242:20 248:22 261:18 264:4 278:3,7 279:17 293:20 303:17 309:13 314:15,23,25 315:5,25 316:11 317:9,13 318:4 319:1,4 320:25 321:2,6</p> <p>patience [1] 346:6</p> <p>patient [60] 79:11 82:9 82:15 89:20 108:12 109:12 113:11,18 114:4 114:6,7,16 121:7,25 123:1,19 124:25 126:16 127:24 129:3 141:7,11 142:3,5,12 143:12 147:14 148:25 149:8 153:22 158:2 181:2,24 183:19 185:5,19 202:6,8 205:8 210:21 249:16,22 250:1 251:4 256:15 259:20 260:19 273:19 275:12 288:14 303:7 304:15 319:20 325:4 334:17 335:25 337:5 360:13 364:11 369:9</p> <p>patient's [14] 77:24 144:23 152:16 181:6 228:14 251:10,20 252:17 281:14,23,24 305:8 306:9 330:21</p> <p>patients [86] 73:8 77:18 77:22,22 78:2,3 79:4,6 79:20,21,24 80:11,15 82:13,23 83:23 84:24 85:3,9,13 87:14 96:8,9 100:20 106:10,11,16 108:22 109:16,21,24 111:3,13,17 112:23 116:9 116:9 121:5 122:19 126:22 140:15 149:9,10 150:13,18 152:6 153:21</p>	<p>153:23 155:25 161:10 168:5 169:5 170:23 178:21 182:25 200:21 247:24 266:21 273:22 274:1,2,3 300:4,11,11 301:5,10,15 302:13,25 303:16,18 305:22 318:5 319:18 324:7 325:9 327:7 329:25 334:20 335:2,4,4 335:7,14,17</p> <p>Paula [1] 176:7</p> <p>pay [1] 17:10</p> <p>paying [1] 275:3</p> <p>PCU [1] 24:15</p> <p>peer [1] 247:25</p> <p>peers [1] 63:15</p> <p>Peggy [16] 12:13,19 24:19 186:19 196:5 198:8 199:2 208:5,8,20 218:18 219:13 277:24 278:16 341:18 343:3</p> <p>Peninsula [1] 266:20</p> <p>Peninsulas [1] 269:19</p> <p>Peninsulas' [1] 266:21</p> <p>people [40] 23:22 25:24 25:25 27:17 59:10 75:25 76:6 83:5,10,17 84:11 97:18 120:9 128:13 136:5 136:6 153:20 154:20 176:8,18 195:2 196:2 203:1 204:4 223:5 229:2 229:3 235:7 248:22 265:25 279:4 280:9 290:14 307:17 315:10 317:1 325:16 328:10 352:11 368:3</p> <p>per [7] 181:22 199:19 204:25 250:9 251:1,4 319:20</p> <p>percent [93] 35:20,22 40:6,16 41:1,20,22 42:13 47:22 49:19 50:20 78:2 78:20 79:21 80:8 84:18 96:17 97:3,5,5 98:1 99:2 102:4,17 107:24 132:6 138:2 145:17,21 146:9 163:25 165:10,10 167:2 167:23 169:4,5 170:25 171:1 175:25 177:6,7,8 263:11,11,12,12,20,22 264:7,8,8,8,12 265:7,11 265:17 266:1,11,12,14 267:8 268:9,18 269:12 269:15 270:4,5,10,11 273:13,15 282:14,18,18 282:19 283:8,8,12,16 297:7,10 298:9 299:6,7 299:18,19,20,20 300:4 302:25 342:4 344:11</p> <p>percentage [6] 42:3 166:4 171:20 266:4,7 298:6</p> <p>percentages [3] 168:6 168:16 297:24</p> <p>perform [16] 44:11 158:25 183:16 186:20 199:13 200:20,25 203:13 279:23 304:11 311:21 315:3 319:5,3 322:20</p>	<p>323:10</p> <p>performance [3] 198:25 274:9 298:9</p> <p>performed [18] 10:24 169:23 180:20 181:7 182:17 185:10 196:20 202:7 204:25 237:8 242:21 249:21 273:19 279:8 300:20 301:5,16 322:7</p> <p>performing [12] 187:20 199:22 208:6 213:21 217:7 223:24 237:3 240:19 277:17 279:4 314:9 338:19</p> <p>perhaps [17] 84:2 90:3 96:2 110:7 120:21 134:4 136:10 143:25 146:16 148:21 149:13 157:18 196:18 223:11 348:14 358:14 375:23</p> <p>period [54] 17:3,4 21:23 168:9 174:22,24 191:9 196:13 208:19 209:11 216:13 217:18,23 220:7 220:16,21 221:2 222:2 233:10 245:17 257:12,16 263:17 265:9 268:15 272:18 277:18 278:18 283:20 284:13 293:16,25 298:6,7 300:13 303:1,9 311:10 321:19 330:4 338:20 340:9,11 342:2 342:18 343:16,23 344:2 349:24 350:3,9 359:11 364:2 369:24</p> <p>periodic [1] 221:9</p> <p>periods [4] 167:17 174:10 273:12 342:8</p> <p>permanent [3] 197:10 197:10 318:3</p> <p>permitted [1] 91:15</p> <p>peroxidase [2] 226:18 226:19</p> <p>person [19] 24:15 75:9 94:2 111:2 132:9 138:16 140:20 141:17 155:1 203:22 208:2,9 214:25 219:13 223:4 326:24 350:11,13 364:8</p> <p>person's [2] 84:16 257:7</p> <p>personal [7] 191:25 324:16 326:2,18,23 327:2 327:6</p> <p>personally [1] 101:15</p> <p>persons [2] 277:17 325:7</p> <p>perspective [17] 30:25 54:1 112:19,24 113:8 138:19 140:1,8 141:15 144:22 145:6 147:19 159:6 166:3 263:19 264:1 296:16</p> <p>Peter [5] 1:9 2:3 4:3,5 349:25</p> <p>Pg [25] 3:3,4,5,6,7,8,9,10 3:11,12,13,14,15,16,17 3:18,19,20,21,22,23,24 3:25,26,27</p>	<p>Pgs [6] 2:3,4,5,6,7,9</p> <p>pH [7] 9:23 49:15 50:12 50:13,23 51:3 238:21</p> <p>phase [1] 152:22</p> <p>phosphate [2] 50:10 257:9</p> <p>physical [4] 58:2,13 287:20 296:8</p> <p>physically [5] 91:20 290:2 304:16 369:16 370:12</p> <p>physician [4] 29:7 112:2 114:13,13</p> <p>physicians [7] 4:7 22:21 58:9 334:19 350:14 363:18,21</p> <p>pick [4] 281:10 285:7 343:1 369:8</p> <p>picked [4] 303:15 368:1 368:6,12</p> <p>picture [6] 21:17 149:14 149:17 170:22 184:11 196:17</p> <p>piece [14] 10:6 64:25 74:3 116:17 119:24 153:17,24 155:18 159:25 162:1 199:10 238:7 319:2,5</p> <p>pieces [2] 5:22 9:23</p> <p>Pike [1] 1:14</p> <p>Pilgrim [3] 81:16 116:18 176:7</p> <p>Pilgrim's [1] 110:2</p> <p>pipette [1] 5:19</p> <p>pipetter [1] 6:3</p> <p>pipetters [1] 6:2</p> <p>pipettes [1] 9:21</p> <p>place [31] 7:19 26:5 30:5 49:8,9 50:23 56:19 57:25 67:22 133:16 157:4 190:20 195:10 199:11 201:14 216:12 232:9 286:20,22 287:7 291:6 293:19 296:9,10,22 316:11 322:16 339:20,23 340:7 357:18</p> <p>placebo [2] 252:4 257:10</p> <p>placed [5] 138:9 159:20 192:22 241:17,20</p> <p>placing [1] 231:2</p> <p>plain [1] 231:9</p> <p>plan [9] 53:12 58:19,22 61:23 62:18 63:23 159:14 353:13,17</p> <p>planning [4] 53:20 194:21 247:1 371:24</p> <p>plans [3] 53:4 57:25 116:14</p> <p>plasmic [1] 104:18</p> <p>plate [16] 227:5,7,15,18 227:19 228:13,23 229:5 229:13 231:3 232:7 233:15,17 238:19 240:8 240:16</p> <p>plates [1] 231:20</p> <p>platform [1] 7:18</p>
--	---	---	--	---

<p>play [2] 216:25 334:16 players [2] 81:20,22 pleased [1] 324:10 plus [4] 87:7 169:20 275:3 374:15 point [60] 10:18,23 11:1 11:3,25 14:11 15:16 17:25 34:5 39:18 44:15 46:7,9 47:5 53:24 55:16 57:16 60:17 61:11 67:20 68:10 69:3,5 73:4,6,24 75:22 77:2,8,8 83:4,11 158:23 160:12 192:22 211:20 215:10 217:25 220:6 229:5,10 231:21 232:7 236:11,11,19 240:17 251:10 257:14 269:11 271:6 273:25 276:18 277:1 279:21 280:16 287:3 301:13 350:1 364:9 pointed [1] 44:21 points [1] 31:23 policies [8] 13:21 73:16 76:10,12,13,22 350:15 363:5 policy [2] 49:16 350:15 pool [2] 272:13 316:10 poor [2] 274:10,24 population [1] 325:5 portfolio [1] 361:2 portion [4] 82:3,4,8 264:9 position [41] 42:19,20 42:25 44:16 72:10 161:3 215:9 219:19,24 220:4 220:20,25 221:4 283:19 283:21,23 284:4,11,24 298:10,13 299:12 316:24 325:14,20,21 348:25 349:1,4,9 350:9 356:13 361:21 370:19 372:14,18 374:4,20 375:15,16 376:2 positions [1] 375:17 positive [160] 30:2 37:9 42:2,3 47:10 78:15 79:5 79:10,23 80:12,16 82:2 82:6,10,11,12,13,14,16 82:16,19,24,25 83:1,1,5 83:12,19,23,25 85:1,12 85:15 86:3,25 87:5,8,16 87:17 88:6 89:7,8 92:9 92:10,17,20 96:9,13,15 97:25 98:14,16,18 99:1 99:6,9 100:20 101:4 103:24,25 104:20 108:16 108:17 111:25 112:8 113:18 114:14 115:7 117:18 126:6,22 127:1 127:18,25 138:23 143:8 143:10 144:11 145:7,11 146:14,16,23 147:24 149:12 150:14 162:3 164:10,13,14,15,15,21 164:23,25 165:6,7,9,11 165:18 168:19,20 170:8 170:25 173:23 175:23 177:6,7 178:20 179:5 209:17,18,19 210:1,10</p>	<p>234:1 235:17 248:25 249:11,19 250:17 251:3 252:16 255:10,15 258:13 258:14 259:19 260:18 262:14 263:5,10,13,21 264:7,8,10,24 265:12,25 266:2,6,6,6,12 267:4,4,5 269:25 274:2,5 275:19 283:10 284:21,21 299:5 299:19 302:14 330:20 332:12 positive/clinically [1] 282:11 positives [35] 80:9,18 81:10 85:17 88:10 98:21 103:5 104:6 109:4 143:24 144:3 147:6,18 148:10 148:15,24 149:5,7 150:18 151:11 161:17 165:8 166:12,17 170:8 252:24 253:2,3 262:19 266:5 269:5,5 270:8 298:1 331:5 positivity [40] 87:2 166:5,8,10,11,22 167:2 169:3 171:7 172:13 175:10,24 263:16 264:12 264:19 265:8 266:13 267:8 268:9 269:1,13,15 269:22 270:21,22 271:4 271:23 273:13 274:10 282:12,15,18 283:20 284:5,12,17 297:6,11 299:18 308:23 possibility [3] 74:18 308:7 316:21 possible [5] 104:22 134:7 137:24 228:13 336:17 possibly [1] 335:16 pot [8] 227:17,19 231:3 231:11 233:17,19 238:20 240:15 potential [2] 115:21 133:8 pots [1] 231:20 powder [1] 50:17 powders [2] 50:1,5 PR [60] 26:11 98:14 112:9 115:7 117:9,10 121:2 123:21 124:11 125:13 126:9,25 127:18,25 129:3 131:3,11,12,14 132:2,15 134:2,14,22,24 135:1,4 135:20 141:5,23 142:6 145:13 146:11 159:14 160:6 161:8 164:14,15 164:15,21 165:8,10,15 165:16,20 166:11 178:20 209:18,19 247:22 249:22 250:2 329:3,4 331:12 332:8,9,14,16 333:7 Prabhakaran [2] 194:9 315:23 practical [1] 91:20 practice [5] 48:2 126:23 127:9 188:9 369:1 practices [1] 321:13 practises [1] 321:7</p>	<p>pre-analytical [1] 213:22 Predham [100] 2:8 55:22 81:17 84:13 90:7 92:1 93:21 101:23 105:15 106:21 132:7 138:15 139:16 146:18 156:1 162:21 235:5 258:23 260:6 298:3 328:10,14 345:16,17,22,23 346:2,3 346:7 348:14,17 349:19 350:2,10,21 351:8,13,17 351:21 352:6,13,18,24 354:13,21 355:19 356:1 356:9,15,20 357:19 358:5 358:10,15,22 359:1,7,15 359:21,25 360:5,15,23 361:4,8,16 362:8,12,19 363:2,14,19 364:5 365:2 365:8 366:10 367:5,11 367:23 368:18 369:11,18 370:13,21 371:1,17,21 372:6,11,22 373:2,8,14 373:20 374:6,17,21,25 375:4,11 Predham's [3] 136:4 140:20 161:15 prefer [1] 146:22 preliminary [1] 88:1 premises [3] 351:22 353:5,20 premixed [1] 50:17 preparation [7] 48:25 49:7 191:15 274:11,16 276:20 336:7 prepared [11] 86:7 93:19 121:1 166:21 176:10 262:25 263:1 297:19 315:17 327:8,22 presence [2] 179:4 262:13 present [7] 37:19,20 40:1 70:8 195:8 208:12 257:24 presentations [1] 13:3 presented [1] 297:5 president [9] 19:8,13,14 19:14,15 20:7,7,8,9 presidential [1] 19:13 press [3] 70:16,18 71:4 pressure [6] 229:2 230:21 231:23,25 232:13 326:17 presumably [4] 14:17 15:9 49:3 248:23 presume [2] 24:21 328:21 pretty [21] 16:7 25:12 27:9 28:12 40:13 49:25 50:12 53:6 62:22 89:25 130:23 163:25 169:9 213:19 214:2 217:14 221:11 243:8 244:18 273:4 322:18 prevalent [1] 127:9 prevent [3] 252:24 253:1 253:5 preventative [1] 8:21</p>	<p>preventive [1] 334:21 previous [8] 31:18 34:9 44:4,5 46:4 197:12 365:11 372:18 previously [3] 4:8 31:15 42:7 primaries [3] 163:23 164:2,5 primarily [4] 16:22 19:5 148:8 216:20 primary [13] 31:20,25 32:18 34:11 123:2 181:4 187:12 188:17 207:21 301:6,12 302:1 364:14 principles [3] 13:20 322:9,13 printed [1] 154:17 Pritchard/Jackie [1] 1:8 Pritchett [2] 1:16 72:11 privilege [1] 268:1 problem [14] 14:7,18 32:21 115:21 139:1 224:3 280:19,22 281:1,5,6,10 346:8 368:22 problems [6] 14:5 223:23 246:25 276:19 281:16 324:16 procedure [73] 13:21,21 48:14 49:8,9,24 104:9 179:16 184:22 190:8,9 190:11,12,15 193:3 194:17 196:19 210:18 211:7 223:25 226:21,23 228:12 234:14,20 235:19 236:1,5,8 237:19,21 238:6,15,18,21 239:3 240:20,24 242:12 243:23 244:2,3,5 245:12,18,23 249:21 251:18 252:2,6 256:13,21 257:2 259:5 260:8 309:7 310:4,22 311:21 314:9 338:25 339:1,16,20,23 340:7,22 341:12 343:5,8,25 344:3 350:16 procedures [11] 7:19 186:20,21 190:2 208:7 260:15 310:4,9 338:11 338:17 363:9 process [26] 24:14 50:23 56:19 66:1 110:11 127:13 152:5,23 195:17 208:1 213:20 226:24 236:3 242:5 249:1 293:19 303:5 311:2,2 317:14 335:10 337:4 341:3 353:22 357:4 365:17 processed [3] 54:19 255:16 282:13 processes [2] 201:23 317:9 produce [5] 230:14 256:23 265:2 268:14 334:18 produced [2] 199:2 204:12 product [3] 189:11</p>	<p>259:18 281:7 production [2] 230:16 230:17 productivity [2] 290:16 295:11 profession [4] 20:16 21:17,22 103:5 professional [8] 13:5 18:21,23,24 22:8 335:15 337:21 348:16 proficiency [12] 67:9,11 67:21 68:8,11,23 69:6,9 211:15,22,24 212:18 profile [2] 5:9,11 progesterone [1] 26:10 prognosis [1] 334:20 prognostic [1] 257:21 program [51] 4:22,23 5:9,23 6:3 7:22 8:11 9:2 9:3 14:10,13 15:18 43:15 52:13 68:20 69:8 76:20 90:10,12 91:7 92:4 94:22 99:11 100:22 102:3 112:25 114:23 115:9,23 159:10,11,16 186:1 199:8 213:4 283:18 288:25 295:23 317:25 321:1,25 350:24 356:24 358:3,11 359:4 361:18,24 362:2,3 364:15 programs [17] 5:7 67:9 67:12 69:13 209:7 211:10 211:14,15 356:22 357:1 357:1 358:4,21 363:1 366:23 367:4 369:25 progress [2] 294:7,17 projects [1] 360:18 proper [5] 66:23 264:18 264:21 316:24 325:14 properly [8] 7:16 8:1,6 16:10,23 65:20 316:22 316:22 property [1] 367:16 proposal [7] 39:14 40:3 40:7 52:16 57:5 313:6 316:15 proposition [1] 204:2 protected [3] 61:15,16 63:11 protein [1] 226:13 protocol [7] 7:9 49:17 229:21 231:4 236:2 248:2 340:24 protocols [3] 66:23 310:23 311:22 provide [7] 24:9 65:15 245:13 259:4 260:7 296:12 313:12 provided [5] 117:5 157:1 204:23 230:6 255:6 providing [1] 247:23 province [8] 5:7,8 46:23 47:2 48:10 66:9 119:5 285:19 PRs [1] 133:8 psychiatric [3] 348:20</p>
--	---	--	---	---

<p>348:22 349:18 public [3] 20:14 71:9 193:2 published [1] 247:25 pull [3] 58:10 95:3 196:18 punitive [2] 365:11,15 purchase [1] 319:16 purchased [1] 49:4 purchasing [1] 214:12 purpose [2] 108:19 262:12 purposes [10] 73:17 76:19 122:6 176:9 179:25 182:21 183:2 184:1,15 184:16 put [30] 7:23 8:3 30:20 52:16 56:19 77:3 82:20 83:2,11 153:15 164:20 169:14 204:19 227:6 231:15 269:8 275:18 286:25 287:11 303:2 304:13 305:7 311:9 315:6 322:6,15 325:20,21 329:25 334:12 puts [1] 286:21 putting [11] 32:16 55:18 63:6 64:15 121:6 240:8 282:15 287:6 293:19 326:15 365:17 pyrex [1] 227:13</p>	<p>186:18,25 187:6,25 188:5 188:24 189:7,15,23 190:5 190:17,25 191:20,24 192:4,11,17 193:11,22 194:1,12,19 195:7,15,22 196:7,16 197:2,11,16,21 198:2,13,17 200:5,13 201:5,18 202:10,17,21 203:3,15,25 204:13 205:4 205:10,14 206:9,13,17 206:22 207:1,5,15,24 208:11,18,25 209:24 210:6,13,20,25 211:4,8 211:17 212:2,12,16,22 213:5,9,14 214:6,11,16 215:3,7,13,18,23 216:2 216:10,17,22 217:3,10 217:19 218:4,10,15,23 219:3,18,23 220:3,9,14 220:19,24 221:6,12,17 221:22 222:1,6,10,15,20 223:1,10,15 224:9,15,24 225:11,19 226:1,6,17,22 227:2,16,23 228:20 229:8 229:14,18 230:2,8,18 231:10,14,19 232:1,10 232:15 233:2,8,14,18 234:6,10,17,23 235:12 235:22 236:9,15,20 237:5 237:12 238:1,8,12 239:1 239:10,16 240:2,14,25 241:5,11,15,22 242:2,13 242:17 243:5,9,14,18,22 244:6,21,25 245:7,14,22 246:2,9,22 247:12,19 248:12,18 249:6,10,14 250:6,12,16,20,25 251:8 251:15 252:7,12,22 253:4 253:9,21 254:5,10,17,24 255:4,11,19,25 256:5 257:13 258:1,8,16,22 259:12,25 260:5,13,24 261:8,14,23 262:6,11,17 262:23 263:4,14,24 264:11,17 265:1,13 266:16 267:1,12 268:5 268:16,24 269:7,20 270:2 270:9,14,20 271:2,11,16 271:21 272:7,17,23 273:8 274:7,19 275:4,17,23 276:3,11,17,25 277:8,15 277:21 278:10,17,22 279:2,9,13,24 280:5,18 280:25 281:11,25 282:7 283:5,11,17,25 284:6,23 285:3,20,25 286:7,14 287:13,18 288:3,12 289:1 289:6,10,17 290:23 291:5 291:10 292:4,8 293:4,10 294:5,12,16,21,25 295:5 295:12,19 296:1,11,23 297:16 298:16,20,25 299:8,22 300:9,21 301:8 301:17,23 302:5,11,17 302:22 303:6,12,24 304:3 305:2,9,13,21 306:10,15 306:19 307:1,9,15 308:1 308:8,19 309:5,12,18,22 310:8,15,19 311:11,16 312:1,9,13,23 313:10,19 314:1,11 315:8 316:12 317:17 318:10 319:8,23 320:2,10,16 321:18 322:5</p>	<p>322:23 323:3,12,24 324:5 324:25 326:1,10 327:1 338:4,5,23 339:5,13,17 340:4,14,20,25 341:10 341:17,23 342:6,11,17 342:22 343:10,15,22 344:1,7,12 345:2,10,14 345:18 346:1,5,9 347:9 348:13 349:14,21 350:6 350:18 351:4,10,15,19 352:3,8,16,20 354:10,15 355:13,21 356:3,11,17 357:14 358:1,8,13,17,24 359:5,10,17,23 360:2,12 360:20,25 361:6,10 362:6 362:10,16,21 363:11,16 364:1,25 365:4 366:2 367:2,7,18 368:15 369:4 369:13 370:10,17,23 371:15,19 372:3,8,19,24 373:4 374:1,9,19,23 375:2,9,22 Q.C./Jane [1] 1:9 QI [2] 152:21 153:21 QMPLS [1] 311:2 qualified [1] 337:15 qualify [1] 263:25 qualitative [1] 360:7 quality [116] 21:11,12 42:20,24 43:4,7,14,24 44:1,16 54:7,24 67:10 89:23 115:22 188:2,13 188:16 189:3,11 199:1 201:14,20 204:4,11 209:4 209:6,12,15,20,21,25 210:3,8,15 211:5,10,14 249:1 274:10,24 277:11 312:14 318:14 320:8 321:16 323:22 327:25 348:23,25 349:2,7,10 350:24 351:6,9,11,23 352:2,4,12,14,22 353:1 353:1,8,9,11,13,15 354:16,20,24 355:24 356:14,18,21,24 357:17 357:17,21,21,23 358:20 360:4 361:1,17 362:13 362:24 364:4,7,19 366:17 369:20 370:1,5 371:5,6 371:9,12 372:12,16,17 372:21 373:5,6,12,15,17 373:18,21,22 374:2,7,15 375:7 quarter [1] 367:14 quarterly [2] 366:22 367:4 questions [14] 4:13 24:22 51:6 74:23 177:11 204:22 219:14 223:5 236:25 251:13 267:19 291:25 325:13 338:1 quickly [3] 4:16,20 368:1 Quinn [3] 117:5 125:4 133:25 quite [10] 21:24 31:13 117:7 134:7 165:20 256:9 272:20 318:19 346:12 364:9 quoted [1] 268:8</p>	<p style="text-align: center;">-R-</p> <p>r [1] 207:17 raise [1] 55:9 raised [3] 42:21 295:15 295:21 randomly [1] 83:20 range [5] 107:19 241:21 241:23 282:17 297:6 rare [7] 99:4,6,16 102:16 103:10,14 126:7 rate [36] 99:1,14 162:3 166:11 167:2 169:3 171:7 172:14 175:10,24 263:6 263:16 264:13,19 265:9 267:6,8 268:9 269:1 271:23 282:12,15 283:13 283:15,20 284:5,12,17 297:6 298:5,10,17 299:13 307:20 308:23,25 rates [10] 163:2 164:10 166:8,10,22 269:22,25 270:22 274:5,10 rather [5] 231:11 251:1 265:4,6 312:10 rationale [1] 197:3 re-rig [1] 177:19 reached [1] 241:21 reaches [1] 240:12 read [23] 12:24 25:13 33:19 104:17 147:4 193:15 209:19 214:24 251:21 256:19 259:15 267:2 274:20 275:10 276:6,8,13 281:8 289:18 289:25 290:9 291:22 307:10 reading [15] 38:5 60:12 61:4,5 191:16 193:16 217:15,24 255:12 281:14 281:24 306:5,7 317:16 320:15 readings [2] 262:14 304:9 readjusted [1] 163:7 reads [2] 234:11 264:5 ready [2] 239:17 276:13 reagents [5] 199:6 200:18 214:12 316:9 319:16 real [1] 172:13 reality [1] 320:18 realize [3] 32:19 213:20 316:25 realized [2] 316:19 335:18 reallocating [1] 314:2 really [40] 6:15 8:1,20 9:12 18:5 19:7 25:10 28:16 32:11 58:6,15 70:3 96:21 102:20 117:14 123:19 169:18,19 171:13 188:4,11,17 191:17 198:6 198:7 216:24 217:4 251:13 254:15 260:20 265:24 284:20 296:15</p>	<p>298:13 307:23 309:4,4 314:14 326:19 365:25 realm [1] 296:17 reason [20] 76:17 85:5 91:9 92:9 94:6 96:11 103:24 114:16 116:7 130:11 134:4 139:8 156:12 185:14 271:22 273:18 274:8 281:15 301:20,22 reasonable [2] 270:22 271:5 reasons [4] 16:11 92:16 104:5 318:11 recalibrate [1] 7:9 receive [3] 38:24 54:23 191:11 received [3] 114:16 176:8 193:4 receiving [8] 31:9 32:10 61:11 66:24 95:20 154:16 193:5 244:9 recently [3] 261:6 272:20 321:21 receptor [3] 1:2 225:13 377:4 receptors [2] 37:8 39:9 rechecked [2] 83:20 84:20 recipe [1] 312:4 recipient [4] 105:13 106:6 117:4 176:5 recognition [1] 46:24 recognize [3] 32:16 106:4 229:23 recognized [6] 27:25 45:14 46:1 215:10 334:16 337:12 recognizing [5] 6:23,25 64:20 68:17 138:21 recollect [1] 58:20 recollection [4] 37:22 151:21 191:21 291:24 recommendation [4] 214:19 260:23,25 319:1 recommendations [3] 214:22 291:16 317:7 recommended [7] 112:1 114:12 238:15 239:4 262:10 311:5 341:15 recommending [1] 60:10 record [3] 223:21 305:1 318:3 recorded [1] 153:17 records [1] 90:2 rectified [1] 15:5 recurrence [1] 324:12 redacted [1] 84:16 redone [1] 80:23 reduce [4] 253:2,5 262:13 334:11 reduced [2] 256:15 334:23</p>
---	--	--	---	---

<p>reducing [1] 312:18 refer [6] 64:9 146:22 150:20 152:11 165:13 283:12 reference [5] 39:6 204:15 227:4 297:4 313:14 referenced [3] 105:16 105:16 318:16 references [2] 87:5 164:9 referral [2] 46:22 64:24 referred [2] 240:4 323:6 referring [10] 31:16 67:12 164:13 178:16 202:5 210:4,9 248:5 321:23 344:4 refine [1] 180:2 refined [1] 301:1 refining [1] 182:22 reflected [2] 88:17 89:1 refresh [1] 38:12 regard [2] 95:7 173:16 regarded [1] 295:20 regarding [3] 73:14 193:3 334:5 regardless [2] 140:6 221:5 region [3] 121:22 158:10 275:13 regional [3] 1:10,17 375:21 regions [3] 122:9,11 160:10 Registrar [20] 31:6 36:18 191:1 204:14,17 255:23 259:8 266:17 276:1 291:11 297:2 312:25 319:25 320:5 338:9 339:7 345:19,24 347:6,7 regular [5] 14:7 24:22 47:8 162:13 253:11 regulated [1] 355:2 rehydrate [1] 238:23 reinforcing [1] 66:15 relate [2] 159:15 300:22 relates [2] 76:3,24 relating [1] 105:4 relation [8] 25:16 187:9 221:2 292:17 295:4,6 300:1 324:15 relations [1] 20:14 relationship [2] 193:18 219:16 relative [1] 75:5 release [3] 70:18 71:4 284:16 releases [1] 70:16 relevant [2] 284:13 349:22 reliable [2] 247:22 281:14 relied [5] 183:1,25</p>	<p>188:19,22 311:23 reluctance [1] 23:2 rely [5] 186:19 188:25 214:2 334:20 364:23 relying [5] 100:14 149:11 150:1,5 248:21 remain [1] 52:4 remained [2] 370:18 372:4 remaining [1] 330:15 remember [22] 15:22 17:1 32:9,13 35:11 37:12 37:14 39:18 40:11,12 71:12 74:2 76:6 136:25 193:13 196:11 235:6 254:21 313:4 317:21 359:4,8 remembered [2] 36:7 193:21 remind [1] 361:3 reminder [3] 224:10 268:6,7 removed [2] 164:2 301:7 renal [1] 69:6 renovate [1] 53:5 repeat [1] 129:5 repeatedly [1] 240:4 replace [1] 290:13 replacing [2] 76:11 229:12 replied [1] 274:24 report [28] 5:15 14:6 25:24 26:5,15,17 27:15 29:6,6,9 33:1 44:23 63:14 82:18 152:16,17 214:18 267:19 305:8,24 306:8,9 314:14,21 330:21 366:3,22 369:6 reported [26] 25:17,22 25:23 35:8 37:4 40:5 60:3 82:9 166:5 170:25 171:1 209:9 263:9,21,22 266:12,14 306:12 307:18 331:11 365:23 371:8,23 372:17 374:7,12 reporting [29] 25:7,12 34:19 35:5,7 37:2,7,21 39:12 40:5 181:17 296:4 304:8 336:12 354:3 361:19,22 363:4 365:5 365:12,15,22 366:17,24 372:21,23,25 373:7 374:16 reports [12] 25:13 82:9 154:17 180:22 267:2 301:4 303:18 306:5 362:2 364:13 366:15,19 represent [1] 4:6 representative [2] 64:8 70:6 representatives [1] 29:16 reprocessing [1] 16:20 reproducible [1] 247:23 request [8] 83:6 91:22 117:6,7 183:15 190:9</p>	<p>304:13 319:3 requested [4] 129:3,5 212:11 253:19 requests [1] 261:19 require [7] 11:19 30:25 31:1 54:13 77:25 290:4 317:2 required [16] 23:6 24:1 24:3 189:2 200:8 201:4 235:6 296:6 313:18 314:8 314:20 315:2,12 316:7 316:16 334:11 requirement [2] 11:24 256:16 requiring [2] 288:7 295:15 requisition [2] 304:10 304:25 requisitioned [2] 303:19 305:23 research [2] 360:7 371:24 researchers [1] 120:17 researches [1] 102:8 resided [1] 273:23 resigns [1] 278:6 resolve [1] 15:10 resolved [1] 15:12 resource [3] 214:25 223:4 350:11 resourced [1] 322:10 resources [37] 60:11,18 119:22 187:14 190:20,24 199:6 200:7 201:3 288:17 289:11,16,16,20 290:5 290:20,21 291:18 295:16 313:18 314:16,20 315:2 315:11,17,22 316:7 318:17 319:2,4 322:19 322:21 323:5,10,13 336:19 337:14 respect [4] 73:3 198:9 209:11 326:23 respects [1] 252:8 respond [1] 324:24 responded [2] 73:4 296:19 responding [1] 364:11 responds [1] 203:21 response [3] 77:13 290:1 293:12 responsibilities [3] 187:8 280:2 361:14 responsibility [26] 59:19 62:10 153:13 188:14 189:17,22 190:23 201:19 202:12 203:1,13 204:10 213:11,15 214:7 218:3 287:15 288:20,24 296:17 324:16 325:2,8 325:22 326:3,18 responsible [30] 10:1 43:6 46:6 75:25 187:19 187:20,21,24 188:1 190:1 201:22 202:22 203:4,22 203:23 204:3,6 205:20</p>	<p>254:2,7 278:11 279:3,14 325:6 358:2,4 361:22,23 362:1,3 rest [1] 120:14 restained [1] 173:23 rests [1] 203:20 result [56] 34:20 46:2 61:19 74:19 79:10,10 82:19 92:16 98:13,15 100:23 111:23,25,25 112:8 113:19,19 114:11 114:14 115:6 118:20 124:8,11,20 126:6,6 129:2 130:3,7 131:2 132:3,3,15 134:24 140:24 141:2 158:3 165:7 172:5 181:1 185:13 264:25,25 265:3 271:4 299:19 305:3 305:7,10,14,17 306:9 307:7,18 329:3 332:12 resulted [1] 88:2 results [102] 37:3 73:3 73:25 74:7,15 77:12,24 78:4 79:24 80:23 82:1,2 82:4,6,21 86:1,25 87:4,5 88:1,9,11,17 90:11,16 90:20,24 91:8 97:11,21 97:25 98:12,17,19 99:9 101:4 105:7,7,19 106:14 109:11,13 110:8 111:16 114:18 117:17,19 121:1 121:25 123:17,20 129:5 131:4 136:12 140:23 149:13 152:13,15,19,20 153:1,4,12,15,19 154:2 154:14 155:10,14,19,23 155:24 156:4,8 157:5,16 160:8 167:1 168:16,18 170:2,4,7,21,24 172:4,8 172:10 173:17 180:1,23 202:7 209:8 228:10 247:23 255:17 266:20 272:13 273:6,7 300:3 334:19 RESUMES [1] 2:2 retain [1] 73:14 retest [16] 81:9 83:24 89:15,19 94:19 105:7,19 129:4 131:4 172:8,10 274:1 303:4 307:2 332:23 335:13 retested [37] 73:9 77:22 78:5,12,14 79:24 82:16 82:25 83:1,6 85:10,14 85:20 88:1 92:11 96:10 96:16 97:11 99:7,9,12 109:16,21 114:6 118:19 124:25 142:13 158:20 173:6 175:21 273:21 306:24,25 330:7 331:21 332:5 333:13 retesting [47] 73:1 77:2 82:15 84:19 87:2,14,23 88:12 90:12 92:4 98:1 99:11 100:18,22 104:1 109:25 111:13 112:9 122:6 123:21 131:12,15 134:19 135:2,5 137:20 140:16,23 145:17 152:6 159:14 163:2 272:22</p>	<p>273:4 329:16 330:1,11 330:25 331:6,21 332:25 333:5,8,15 335:8,23 336:1 retired [1] 219:1 retrain [1] 293:20 retrieval [20] 11:13,15 11:19 104:23 225:1,12 225:25 234:1 235:16 236:3 237:20,24,25 238:3 238:7,24 239:7,24 259:5 260:9 retrieved [1] 261:17 retro [62] 84:25 91:24 92:2 93:2 94:12 95:9,13 95:19 98:9 100:5 103:17 105:4,14 107:5,21 108:1 108:11 110:5 111:22 112:6,11 114:10 116:8 116:24 131:17,21,24 132:5,18 133:2 134:9 135:20,21,24 136:4,6,23 137:4,7,13 138:9 140:9 140:25 141:16 142:1,8 143:5,21 146:22 147:7 148:20 149:6 151:20 160:7 161:8,8,9,12,15 161:16,24 328:22 retroli [1] 328:16 retrospect [3] 312:4,7 320:23 return [1] 345:8 returned [1] 54:20 revalidation [1] 341:9 reveal [1] 225:13 revealed [2] 84:21 299:23 reverse [2] 106:23 136:7 review [23] 5:16 44:12 54:24 55:24 73:18 77:21 80:10 94:18 112:2 114:13 120:23 147:21 148:23 160:22,23 176:9 190:13 210:17 247:25 273:20 274:3 335:10,13 reviewed [11] 95:9 148:19 151:12 152:14 269:19 306:23 311:10 328:16,18 330:1 333:5 reviewers [4] 42:23 43:22 44:4 102:25 reviewing [12] 82:1,3,6 82:8 98:3 116:20 121:4 121:5 199:1 297:4 322:16 335:22 reviews [3] 57:4,5,11 REVISED [1] 3:1 Reza [3] 152:3 153:17 163:13 right [96] 1:8 5:1 6:13 14:17 27:11 29:20 33:12 35:15 36:1,17,19 40:18 40:23 42:5 43:17,17 45:19,23 46:20 52:4 54:17 55:5 59:12 65:18 68:5 69:23 72:14 74:21 76:25 78:3,21 79:22 88:14 90:24 97:20 98:6</p>
--	--	---	---	---

<p>108:14 110:16,20 114:22 119:9 128:19 133:19 136:9 145:1 148:12 150:7 150:17 151:10,18 165:23 166:19 167:8 168:11 170:12,15 171:23 173:9 175:2 181:11 186:2,15 189:4 190:21 197:9 201:21,24 202:14,23,24 217:16 221:18 224:2 225:8 230:10 232:24 237:16 249:17 254:9 265:6 269:8 273:3 282:3 282:8 301:18 305:20 309:15 313:20 314:7 316:17 320:3,12 330:3 341:24 355:22 376:4</p> <p>right-hand [2] 276:10 276:12</p> <p>rigidly [1] 340:10</p> <p>Rigorous [1] 247:20</p> <p>risk [37] 55:2,21 185:5 262:19 312:18 349:5,10 349:11 351:25 354:1,23 359:12 360:3 361:9,12 361:21 362:7,9,15 363:8 370:11,14,18 371:13 372:13,13,17,18,20 373:6 373:13,18,21 374:3,4 375:8,18</p> <p>Robb [1] 287:9</p> <p>role [28] 19:11 64:18,19 94:23 102:1 139:18 145:3 154:13 160:4,4 187:13 198:19 199:4 202:20 203:13 216:6,25 217:14 219:5,8 246:24 287:17 334:16 356:21,22 364:10 364:10,14</p> <p>roles [2] 20:17 364:9</p> <p>Rolf [1] 1:8</p> <p>room [4] 24:9 267:15 270:17 304:8</p> <p>root [5] 139:1 354:7,11 355:17 356:6</p> <p>Rosalind [1] 324:6</p> <p>roughly [3] 179:6 180:5 276:7</p> <p>routine [3] 190:16 213:24 357:7</p> <p>RS [1] 329:6</p> <p>rule [1] 148:1</p> <p>rumours [1] 54:4</p> <p>run [27] 209:16 249:15 249:17,19,20,22 250:5 250:15,21 251:1,4 253:11 253:13,19 254:1 256:18 256:25 257:3,10 258:6 259:19 260:18 261:4 269:21 274:14 275:9 300:12</p> <p>running [8] 145:3 254:22 254:25 257:16,21 258:12 258:14 261:5</p> <hr/> <p style="text-align: center;">-S-</p> <hr/> <p>S [3] 207:17 213:25,25</p>	<p>safely [3] 32:4 34:4 331:18</p> <p>safety [4] 320:11 337:5 360:13 369:10</p> <p>sake [2] 108:25 308:21</p> <p>saline [1] 257:9</p> <p>sample [16] 167:12,14 168:4,20 169:7,18 170:18 171:8,25 172:6 173:2 181:2 251:5 281:15,24 318:7</p> <p>samples [6] 82:24 173:12 211:22 257:6 273:17 335:22</p> <p>Sandra [5] 1:7 2:7,9 338:4 345:17</p> <p>Saskatchewan [1] 205:17</p> <p>sat [4] 62:20 154:3 287:12 289:23</p> <p>satisfactorily [1] 328:1</p> <p>satisfactory [1] 190:14</p> <p>save [1] 255:1</p> <p>saw [10] 14:7 57:6 63:13 64:6 243:15 293:17 308:13 339:9 364:15 367:19</p> <p>says [18] 31:13,22 192:24 194:2 235:1 239:19 244:10 246:13 259:16 262:10 263:11 264:6 276:4 281:16 288:15 290:9 299:6 328:14</p> <p>scenario [2] 251:7,9</p> <p>scenarios [1] 74:17</p> <p>scene [5] 218:24 223:4,6 223:12,18</p> <p>schedules [2] 8:22 203:11</p> <p>scheme [1] 54:25</p> <p>school [2] 13:14 19:18</p> <p>schooling [1] 4:22</p> <p>Sciences [33] 9:25 15:21 22:17 28:4,18,19 29:10 35:24 45:11,14,15,23 46:21 47:15,16,20 48:1 48:5,7 52:22 53:5,9 54:20 56:22 57:18 65:11 119:2 121:9 216:21 218:2 219:11 290:12 370:6</p> <p>Sciences/Janeway [1] 16:17</p> <p>scope [1] 308:10</p> <p>Scotia [1] 278:6</p> <p>screen [2] 191:4 361:19</p> <p>scroll [1] 239:14</p> <p>scrolling [1] 239:14</p> <p>se [1] 181:22</p> <p>search [3] 26:16 27:20 264:22</p> <p>searched [3] 25:19 27:15 300:19</p> <p>searches [1] 300:18</p> <p>searching [1] 26:8</p> <p>seated [4] 4:2 133:22</p>	<p>224:23 291:9</p> <p>second [10] 50:18 66:19 67:7 192:23 230:20 234:25 246:12 277:1 330:3,4</p> <p>seconded [1] 119:24</p> <p>secretary [2] 154:7,17</p> <p>section [13] 26:20 56:15 87:4 178:14,19 180:21 186:8 187:14 214:20 215:8,21 216:5 221:1</p> <p>sections [6] 39:10 56:6,6 56:9 196:22 238:23</p> <p>see [66] 18:16 22:3 36:16 36:19,21,23 37:1 38:9 39:5 59:6 65:7 86:15 94:21 98:3,17 103:6,8 122:25 139:18 144:6 159:4 165:6 168:17,22 169:3,17 171:23 174:13 177:19 191:3 192:23 201:3 204:20,22 205:22 229:19 233:21 234:18,18 240:19,22,23 243:23 246:11 255:8 256:6 259:8 260:14 266:10 267:7 273:20 276:5 282:16 286:8 295:14 297:25 310:6,16 312:21 314:14 320:17 322:22 329:2 338:6 365:6 375:5</p> <p>seeing [6] 17:24 40:7,11 137:8 237:22 367:8</p> <p>seek [2] 280:23 281:2</p> <p>seem [7] 191:2 232:18,24 246:3 295:18 297:11 315:10</p> <p>segment [1] 316:20</p> <p>select [1] 152:5</p> <p>selected [4] 85:12 330:11 331:21 332:25</p> <p>selection [3] 10:6 88:11 330:24</p> <p>send [7] 47:14,25 48:4 48:14 286:25 287:5,6</p> <p>sender [1] 105:13</p> <p>sending [9] 17:7 47:14 56:21,23 88:10,11 122:6 269:10 273:14</p> <p>senior [5] 154:12 214:3 277:2,11 278:7</p> <p>sense [8] 9:6 60:8,12,14 91:21 293:6 309:24 312:3</p> <p>sensitive [4] 71:7,18 85:18 193:3</p> <p>sensitivity [1] 71:6</p> <p>sent [30] 19:16,18 47:18 64:7 65:24 66:7,20 83:24 84:10 85:22 87:14 88:19 88:25 89:13 105:15 109:24 111:12 119:4 162:20 176:6 191:5,5 192:10 193:20 201:7 261:21 275:13 286:2 306:21 307:11</p> <p>sentence [3] 67:7 255:13 259:15</p>	<p>separate [10] 46:10 89:4 122:2 131:15 143:15 257:8 266:3 294:10 328:19,20</p> <p>separately [1] 270:18</p> <p>September [4] 110:3 223:7,19 294:2</p> <p>series [1] 356:25</p> <p>serum [2] 257:8,8</p> <p>serve [2] 335:2,17</p> <p>service [10] 53:7 255:12 288:19 313:13 315:13 322:8 323:4,8,23 350:4</p> <p>services [9] 51:7,15,19 54:13 55:19 58:23 86:8 321:17 363:7</p> <p>session [2] 357:20 363:21</p> <p>sessions [2] 357:22 363:3</p> <p>set [30] 6:9,24 7:6 20:24 21:1,13 22:13 24:15,18 26:12 27:1 28:1 29:1 44:10 49:16,24 50:22 53:12 60:1 158:21 198:21 198:24 230:25 238:15 242:6 243:1 295:6 317:19 343:25 356:23</p> <p>sets [1] 7:21</p> <p>setting [5] 6:10 178:12 198:19 354:18,19</p> <p>seven [7] 50:12,13 80:14 168:4 286:21 297:10 301:10</p> <p>several [9] 20:14 34:17 105:18 117:7 124:21 125:10 134:16 164:10 324:14</p> <p>shared [2] 189:16,22</p> <p>sheet [8] 229:21 259:8 259:10 260:17 261:24 339:3,19 344:3</p> <p>sheets [2] 158:9 343:20</p> <p>shift [1] 318:12</p> <p>short [5] 216:16,18 220:7 257:12 334:2</p> <p>shortly [1] 18:8</p> <p>shoulder [1] 203:9</p> <p>shoulders [1] 279:20</p> <p>show [7] 13:11 36:12 62:11,11 281:6 307:20 365:20</p> <p>showed [12] 116:25 133:24 134:12 135:8,13 137:8 143:24 151:13,18 165:14 266:11 328:9</p> <p>showing [1] 339:4</p> <p>shown [15] 31:7 59:1 67:4 84:3 99:24 105:5 105:21 135:6,17 137:15 140:6 141:4 152:9 156:23 191:14</p> <p>shows [2] 97:20 298:9</p> <p>shutting [1] 287:5</p> <p>sic [1] 174:18</p> <p>side [42] 12:23 17:9 18:1 18:17 51:21,22,24 56:21</p>	<p>56:23 64:11,15 65:25 66:17 68:3,9,19,23 81:15 111:7 137:18 156:3,3,18 164:11 188:12,12,15,15 188:25 189:9,10,20,21 200:1,10 201:2,21 265:23 265:24 276:10,12 277:16</p> <p>sign [1] 281:9</p> <p>signature [2] 192:20,21</p> <p>signed [3] 311:8 313:5 316:14</p> <p>significance [3] 32:5,19 239:21</p> <p>significant [3] 44:21 121:18 169:20</p> <p>significantly [1] 307:24</p> <p>signing [2] 180:22 311:8</p> <p>signs [1] 259:17</p> <p>similar [9] 64:13 117:16 134:16 166:21 295:22 331:25 366:9 368:11,12</p> <p>Simmons [34] 1:10 2:6 230:11 267:17 268:3 324:18 325:10 326:14 327:17,18,21,24 328:4,5 329:1,13,20 330:2,8,14 330:22 331:3,9,16,24 332:4,15,19,24 333:3,11 333:19,24 337:24</p> <p>Simms [2] 45:21 278:8</p> <p>simple [3] 225:2 226:14 281:21</p> <p>simplicity [1] 108:25</p> <p>simplistic [1] 225:7</p> <p>simply [4] 104:17 272:1 297:22 298:1</p> <p>simultaneously [2] 259:20 260:19</p> <p>Sinai [44] 7:23 84:20 85:22 87:17 90:13 92:4 105:19 117:10,10,19 121:2 131:4 134:15 135:2 135:5 152:15 154:16 157:5,15 163:3 172:7,15 173:24 266:23 269:12 270:23 272:15 273:1,5,6 273:15,21,24 282:9 306:21 307:11 310:25 313:15 318:16 322:8 329:3,4 330:25 331:11</p> <p>single [5] 26:15 175:4 249:20 250:5 281:8</p> <p>sit [1] 357:10</p> <p>site [32] 14:21,23 15:11 15:21,23 16:8 17:16 18:5 18:13 28:25 35:15 51:22 56:14 123:1 185:25 216:12,21 217:9,11,20 219:19,24 220:4,6,20 221:13 253:15 316:6 370:4,4,6,16</p> <p>sites [11] 17:22 27:19 29:19 52:5 123:9 225:5 225:13,14 228:14 365:11 370:3</p> <p>sitting [3] 62:17 66:6 196:11</p>
--	--	--	---	--

<p>situation [2] 111:24 112:7 situations [1] 304:21 six [15] 23:19 80:13 168:4 169:4 234:3 239:4 259:3 259:3 273:17 282:4 288:8 288:13 325:3 339:6 357:22 sixteen [3] 97:24 99:8,12 size [12] 167:12,14 168:4 168:20 169:7,18 170:18 171:8,25 172:6 173:2 177:24 skilled [1] 316:2 skills [3] 23:14,17 62:25 slide [19] 47:7,10,11 48:19 104:18 188:22,22 197:10 249:16 252:5 257:25 264:3,5,10 275:10 281:7,9 307:10 318:5 slides [64] 9:23 12:24 45:9,24,25,25 46:6,25 47:4,8,16,17,19,21 48:1 48:6,21 54:20 61:5 64:21 84:21 94:18,19 95:3 148:20 188:21 190:13 199:2 205:3,5,7,8,8 210:5,9,10,18,21,24 211:1 217:15,24 226:14 227:6,14,17 228:12 236:4 237:20 238:22 241:6,16 256:15,22 264:14 274:23 275:9,12,12,14 304:17 307:7 317:16 322:17 slight [1] 354:22 slightly [2] 371:11 375:15 small [15] 106:16 151:8 167:12,14 168:3,14 169:9 171:8,25 172:6 220:7 275:14 290:12 307:16,23 snap [1] 197:1 social [1] 350:3 Society [3] 1:15 19:10 72:22 sodium [3] 50:9,9,9 solicitor-client [1] 268:1 solution [15] 29:19 227:19 228:12 229:4,7 232:6 237:24 238:22,25 239:24 240:8,12 241:6 241:14,16 solutions [2] 242:22 247:1 someone [8] 43:6 75:4 94:15 108:8 110:22 263:11 307:10 325:15 sometime [3] 109:22 358:16,18 sometimes [5] 39:2 138:25 249:21 280:6,7 somewhat [2] 41:18 77:5 somewhere [4] 118:15 232:22 302:9 370:7 soon [1] 76:1 SOP [4] 309:24,25 310:16</p>	<p>312:3 sophisticated [2] 120:20 123:5 sorry [22] 36:16,17 38:3 39:4,7,9 54:5 69:1 82:3 136:15,20 174:11 204:18 207:2 234:11 236:10 270:25 341:15 346:22 373:17 374:22 376:4 sort [46] 8:16 17:9 19:19 20:4,20 21:12 25:18 27:11,13 28:5 29:16,17 29:20,25 31:2,23 42:6 44:4,16 49:6,16 50:22 52:25 53:12 55:9,23 59:25 61:10,13 62:16 63:9,22 64:19,22 65:25 66:14 70:25 71:21 83:2 88:12 89:23 132:22 170:21 205:21 233:9 366:7 sorts [4] 8:8,14 9:23 21:5 sought [1] 319:10 sound [3] 322:9,13 377:10 sounding [1] 233:15 sounds [1] 231:15 source [5] 229:20,21 230:3 249:2 268:22 space [7] 52:25 53:5 57:22 290:3 293:18 295:9 296:18 speak [7] 70:3 75:24 176:21 237:2 294:17 325:16 337:20 speaking [6] 20:20 88:4 153:20 242:8 274:22 294:15 speaks [1] 288:13 spec [5] 259:8,10 260:17 261:24 344:3 special [10] 45:24 46:25 47:4 246:5 288:6,18 296:2,3,4 363:21 specialist [1] 206:2 specific [6] 9:11 35:11 36:1 121:6 254:21 328:6 specifically [18] 44:25 70:14 74:3 75:3 76:6 87:6 102:5 196:2 233:25 235:15 236:4,21 238:9 247:6 258:11 259:2 287:10 293:15 specification [2] 339:3 339:19 specimen [9] 16:11 109:12 113:17 118:22 119:1 251:20 329:5,8,15 specimens [17] 14:8 16:10 54:9,13 56:1,18 56:20,21,24 65:21 259:20 260:19 263:6 269:17 273:15 276:20 316:21 specs [1] 310:9 spell [1] 345:20 spelling [1] 288:4 spelling [1] 288:4 spend [4] 60:25 62:24</p>	<p>63:3 290:8 spending [1] 233:5 spent [7] 22:11,12 82:1,3 82:5 313:25 357:5 spoke [7] 51:5 102:19,24 197:23 199:14 293:1 324:8 spoken [1] 292:11 spot [1] 224:7 Spread [1] 344:20 spreadsheet [4] 122:25 263:1 283:1 330:1 spreadsheets [8] 155:23 156:23 157:4,21 158:12 158:17 297:13 307:25 spring [1] 73:11 squares [1] 291:23 St [82] 13:7 15:22,24 16:8 16:9,21 17:17 18:5,10 23:12 24:16 27:5 28:3 28:17,21 29:9 35:23 45:10,12,24 46:9,13,14 47:23,24 48:3 52:2,15 52:17 53:7,9 54:3,4,13 55:12,20 56:1,22 58:8,8 58:9,12,23 119:1 121:9 121:10 122:15,18,18 123:9 170:9,10,13,23 201:12 228:22 263:6 269:2,14 270:5,23 271:6 272:3,12,15 273:6,13 274:6,13,14 275:11,16 278:4 290:11 316:6 323:20 369:20,22 370:4 370:9 377:7,11 stable [1] 18:6 staff [58] 22:20 24:9,10 59:12 153:14 187:20 195:4 199:11 200:4,25 201:2 202:2 203:10,10 203:12 214:4 218:20 219:6 239:23 261:18 279:19,20,22 285:15,23 286:13 287:22 288:11 290:2,5 296:18 311:21 314:25 317:3,4,24 324:1 334:18 335:9 336:2 337:16,22 338:17 357:16 361:23 362:22,23,24,25 363:5,10,12,15 364:3,7 364:15,21 374:11 staffing [4] 214:8,8 288:7 295:9 stage [1] 252:1 stages [2] 53:20 319:11 stagnant [1] 355:11 stain [4] 184:12 242:24 244:4 255:17 stained [2] 54:19 85:1 staining [33] 41:25 42:1 46:3 47:13 84:21 104:2 104:12,19,19 171:1,2 177:6 179:5,13,25 209:22 213:24 226:16 252:20,21 256:12,15,24 257:1,22 257:24 262:16 263:13,21 263:23 266:14 267:5 269:6</p>	<p>stainings [1] 214:1 stains [2] 184:14 242:21 stand [4] 2:2 39:25 193:23,25 standard [20] 25:12 26:5 28:24 29:1,5,12 200:9 209:6 211:10 309:6 311:4 314:12 315:15 318:14 322:8 338:11,17 339:21 340:21 343:5 standardize [1] 321:12 standardized [2] 37:8 340:7 standardizing [2] 25:5 25:15 standards [1] 138:21 standing [1] 178:10 stands [1] 281:15 start [17] 36:14 39:12,20 61:4,5 74:5 116:19 119:22 200:19 201:4 261:5 278:1 293:19 314:8 320:15 322:10,13 started [23] 100:18,23 118:11 127:15 128:4 152:13 195:4 233:11 256:20 257:2 317:11 323:9 337:4 351:1 352:25 359:3,9 360:10 366:12 366:13 370:2 375:7,19 starting [2] 205:22 282:3 starts [1] 294:2 state [1] 345:20 statement [13] 25:11 68:14,15 86:24 188:4 247:13 248:23 260:17,20 281:21 327:14 333:21 334:2 states [3] 84:15 152:13 311:5 stating [1] 320:22 statistic [2] 173:20 308:16 statistical [1] 298:8 statisticians [1] 120:21 statistics [4] 116:2 162:23 174:17 296:25 status [2] 178:20 251:21 step [17] 178:11,11 234:14,14 235:18,19 236:8,8 237:18,18 238:3 238:4 239:3,3 243:4 339:18,18 step-by-step [1] 339:16 steps [3] 49:6 252:5 277:4 Sternberger [1] 12:16 steroid [1] 39:9 still [36] 6:10 52:23,24 55:12 57:21 72:9 82:14 82:16 84:20 107:6 111:15 140:8 167:25,25 171:23 182:17 188:22 237:7,10 238:18,20,21,22,23 239:14 252:4 265:22 281:8 291:1 308:13,14 336:3 350:7 351:2 359:14</p>	<p>374:20 Stokes [2] 77:15 79:19 stood [1] 303:7 stop [1] 199:22 stopped [6] 48:2 174:15 174:15,18 275:8 286:6 stops [1] 203:16 story [2] 292:5 300:1 straighten [1] 376:6 straightening [1] 320:4 strategic [1] 58:19 stray [1] 160:5 stream [1] 20:3 strictly [2] 170:10 183:17 strike [1] 327:2 strong [4] 165:6 265:11 266:5 270:8 strongly [2] 104:11 266:12 struck [1] 240:3 structure [5] 21:4 197:5 204:8,9 375:13 structured [1] 355:1 students [1] 5:10 submission [1] 313:17 submissions [1] 80:3 submit [4] 12:11 258:20 261:2 323:8 submitted [5] 181:3 310:3 316:23 319:3 343:9 submitting [1] 310:14 subscriptions [1] 61:17 subsection [1] 186:8 substantial [1] 247:24 substrate [4] 227:11 229:4,7 232:6 subtle [1] 355:7 success [1] 99:14 successful [2] 44:18 45:2 such [22] 9:21 18:11 23:25 24:2 37:5 73:18 93:6,7,19 94:11 95:19 104:23 116:8 147:17 168:3 208:2 220:25 221:4 231:2 318:20 325:13 354:7 sucks [1] 226:15 suction [3] 368:2,19,23 suggest [5] 160:6 175:14 265:3,8 270:21 suggested [5] 39:11 40:21 61:19 160:16 201:16 suggesting [9] 60:9 65:10 83:16 256:7 268:11 271:3,19 272:1 282:20 suggestion [4] 39:13 309:1 325:4 345:5 suggests [4] 40:16 131:20 213:2 275:18 suit [1] 205:24 summarize [1] 152:4</p>
--	---	--	--	--

<p>summary [4] 26:4,22 120:18 367:12</p> <p>summer [9] 73:23 83:22 85:5,16 208:14 293:25 321:4 335:12 371:22</p> <p>Sunnybrook [1] 323:18</p> <p>superior [1] 197:12</p> <p>supervise [1] 12:2</p> <p>supervised [2] 198:22 198:24</p> <p>supervising [2] 76:1 198:19</p> <p>supervision [1] 277:11</p> <p>supervisor [7] 10:20,22 11:24 186:6 187:8,24 202:11</p> <p>supplied [2] 12:15 260:11</p> <p>supplies [1] 316:9</p> <p>support [8] 60:23 335:15 336:18,21 337:16 350:13 350:17 356:21</p> <p>supported [2] 64:4 357:1</p> <p>suppose [2] 308:2,10</p> <p>supposed [4] 8:2 103:8 203:14 279:23</p> <p>surely [2] 248:3 267:23</p> <p>surgeons [1] 56:3</p> <p>surgery [5] 55:10,11 123:2 181:4 368:9</p> <p>surgical [2] 125:5 317:1</p> <p>surprised [2] 342:21,23</p> <p>surrounding [6] 5:17 14:4 15:19 21:13 35:6 37:21</p> <p>surveys [1] 169:18</p> <p>Sushil [1] 216:20</p> <p>switch [8] 32:4 33:8,9 33:18 34:4 35:4 48:25 319:3</p> <p>switched [3] 228:4 231:21,25</p> <p>swore [1] 268:7</p> <p>sworn [3] 2:8 345:7,17</p> <p>sync [1] 297:12</p> <p>synoptic [1] 25:7</p> <p>system [71] 22:13,21 23:7,8,18,20 25:2 27:7,9 27:18,18,20,24 28:11,12 28:13,20 29:3 30:6,11 31:19,25 33:21 34:10 71:16,17 85:14,18 87:16 90:14 91:21 106:13 152:17 153:16 154:3,4 154:14 155:2 192:9 209:15,25 210:3 212:17 233:24 235:15 237:11 246:18,21 247:3,14 248:6 248:15 259:6 260:9 280:19 290:19 294:4 303:22 304:14,17 305:7 306:7 307:8 334:9,13 336:21 337:1 349:8 373:15,17,22</p>	<p>systems [9] 24:2 27:2,24 89:21,23 209:4,13 210:8 371:9</p> <hr/> <p style="text-align: center;">-T-</p> <hr/> <p>t [8] 24:8 30:5,8 207:17 207:17 213:25,25,25</p> <p>table [22] 2:1 51:9 121:11 125:14 137:9 155:9 163:1 164:5,9 166:21 171:12 176:14,24 263:15 266:21 267:7 297:25 298:7 299:5 308:20 328:12,18</p> <p>tables [10] 120:24,25 121:21 122:2 123:5,10 155:2 156:21 176:25 268:14</p> <p>tabs [1] 271:22</p> <p>takes [4] 204:18 217:5 286:20 298:1</p> <p>taking [15] 7:19 28:17 28:19 30:5 63:22 67:22 178:25 201:14 218:3 240:6 293:22 296:9,21 297:23 316:11</p> <p>talks [6] 33:1 34:11 65:5 246:23 288:4,5</p> <p>tallying [1] 366:13</p> <p>Tamoxifen [1] 324:14</p> <p>target [1] 50:11</p> <p>task [2] 77:6 184:24</p> <p>tasks [1] 213:16</p> <p>taught [1] 356:6</p> <p>teach [4] 61:3,4 62:25 353:21</p> <p>teaching [5] 312:22 321:5,9,13 322:3</p> <p>team [5] 59:23 317:1,15 353:23 357:23</p> <p>tech [1] 154:13</p> <p>technical [26] 22:20 57:17 59:12 66:1,17 68:9 92:19 96:15 147:19 188:12 189:2,10 226:4,9 237:2 247:21 262:5 263:5 263:7,9 277:4,16 285:15 285:23 286:12 317:10</p> <p>technically [2] 139:22 139:25</p> <p>technicians [1] 23:3</p> <p>technique [8] 32:2 33:24 178:17,25 229:9,12 245:2 255:18</p> <p>technologist [19] 6:24 18:17 21:7 43:25 64:10 207:8,20,23 209:16 219:16 261:25 277:3 278:5,7 304:11,12,22 334:24 341:12</p> <p>technologist's [2] 61:11 253:17</p> <p>technologists [56] 5:18 14:5 15:2,19 16:21 17:25 19:10 22:25 23:3,16 24:1 46:17 59:13,15 60:10 61:16,24 62:23 63:1,4</p>	<p>63:10,24 64:19 67:1 129:23 140:3 183:15 187:5 188:18 196:6 198:8 200:23 201:15 213:21 214:3,3 224:4 237:3 242:9 244:2 278:16 279:12 290:10 314:18 316:2 321:15 323:16,23 335:21 337:15 338:18 340:10,16 341:25 343:17 343:19</p> <p>technology [14] 4:23 8:11 9:7 13:11 17:9 51:21,23 60:17 64:15 68:19,23 253:23 290:15 300:3</p> <p>techs [15] 47:24 60:23 187:2 197:24 201:7 202:13,22 204:6 213:11 221:9 223:23 240:18,22 293:20,21</p> <p>telling [5] 76:6 275:22 340:6 348:15 365:1</p> <p>tells [3] 168:11 271:23 292:5</p> <p>temperature [8] 7:20 7:22 8:1 227:13 229:22 239:25 240:13 241:2</p> <p>template [3] 29:2 283:2 310:24</p> <p>templates [1] 311:7</p> <p>ten [57] 29:11 37:16 49:19 50:19 92:13 96:6,12,13 97:5,5 100:8 107:8 109:10 134:14,14,17,17 134:18,18,20,20 135:10 135:10 137:11,11,16,16 137:21,21 138:22 139:2 139:3,4,4 140:9 142:6,6 142:13,13 143:2,2 144:7 144:7,9,9 152:12 177:7 186:14 191:18,18 208:7 240:17 277:25 299:19 302:25 304:24 323:16</p> <p>tend [2] 224:11 355:3</p> <p>tender [2] 294:2 368:24</p> <p>term [10] 8:15 71:5 91:25 108:1,6 143:21 146:22 148:21 214:20 355:5</p> <p>terminals [1] 23:21</p> <p>terminology [1] 146:17</p> <p>terms [47] 5:23 6:23 9:20 12:3 14:3 15:4 21:4,21 26:8 42:8 56:7 58:19 59:18,25,25 61:10 62:3 63:7 65:5,23 68:14 70:14 78:19 79:9 83:18 95:12 107:4,21 109:18 115:21 126:20 133:2 139:17 154:1 170:18 176:12 181:16 218:6 225:2 226:4 226:14 243:6 298:6 318:14 364:4 367:8 374:10</p> <p>Terry [9] 2:2 4:3 72:15 177:16 229:21 234:7 246:13 328:4 338:4</p> <p>tertiary [1] 321:9</p> <p>test [95] 9:12 12:4 23:20</p>	<p>30:20 41:25 47:18 73:3 77:12 78:4 79:10 80:5 80:22 82:2,6,19 87:5 90:11 92:16 97:10,25 98:13,14,14,16,18 99:9 100:23 101:4 104:9 111:23 112:8 114:10,14 115:6 117:17,19 136:12 137:15 149:13 157:15 164:21 169:22 170:21 184:12 185:4,9,9 193:1 193:8 194:4,7,10,16,18 194:22 195:18,21 196:1 196:9,14,20 197:5 198:22 200:8 201:4 202:6 236:24 237:4 242:23,23 244:12 244:17,20,22 256:13,14 273:19 277:11 298:1 300:12 301:16,25 304:16 305:23 307:19 312:15 317:11 318:2 319:3,11 324:2 331:18 341:19,19 343:3</p> <p>tested [18] 77:18 79:20 83:23 85:4 142:12 147:23 150:13 158:19 173:13 179:25 266:22 272:25 273:24 302:13 303:1,8 307:3 335:14</p> <p>testified [21] 4:7 13:2 18:25 19:1 32:12 45:9 55:15 58:18 59:3 70:24 187:1 194:6 289:25 290:17 309:19 310:24 323:19 324:6,8 325:3 329:23</p> <p>testify [5] 98:25 116:18 176:19 201:12 337:23</p> <p>testimony [16] 4:14 12:11 132:17 186:13 204:16 214:24 250:8 275:24 281:19 282:1,8 286:19 291:12 309:11 321:4 337:4</p> <p>testing [103] 1:2,13 33:4 33:7 63:19 67:9,11,12 67:21 68:8,10,11,23 69:6 69:9 73:25 83:15 121:13 147:22 163:15 174:18 178:9,14 180:7,9,20,23 182:23 183:4 184:7,22 187:10,12,21 195:5 199:10,22 200:2,22,24 201:1,14 205:20 208:9 209:12 211:15,24 212:18 216:25 217:13 225:24 226:23 228:4 232:5 236:2 236:21 237:8,14 239:9 246:11,20,25 247:15,18 248:1 258:7 261:6 272:13 277:25 278:1 286:6,21 287:5,6 300:5 304:11 305:4,6 309:14 310:1 313:13 315:3,5,13,24 316:3,5 318:15 319:5 322:7,15,20 323:10,17 324:15 331:20 336:10,11 336:13,16 337:2 340:8 377:4</p> <p>tests [11] 78:20 198:19 200:19 204:25 300:19,20</p>	<p>301:5 304:23 331:11 333:4 338:19</p> <p>text [2] 50:12 328:14</p> <p>textbook [3] 12:16 50:11 51:2</p> <p>TG [2] 234:9,11</p> <p>thank [33] 42:17 72:1,5 72:7,14 165:25 177:10 191:4 206:25 224:16,25 256:4 259:7 275:24 285:4 320:3 327:19 334:2 337:18,23,25 344:13,15 344:15,21,23 345:9,11 345:25 346:6 347:10 348:14 376:7</p> <p>Thanks [4] 178:7 204:21 224:10 291:11</p> <p>theme [1] 337:6</p> <p>theory [8] 9:15,18 12:12 12:14 13:20 61:18 63:2 252:23</p> <p>therapeutic [4] 183:2 184:1,16 185:14</p> <p>therapy [22] 73:10 77:19 78:17 79:7,7 80:17 114:8 114:20 128:1,15 136:9 140:16,17,22 150:22,23 184:25 185:6,20 196:15 308:3 326:4</p> <p>thereabouts [1] 314:3</p> <p>thereby [1] 293:22</p> <p>therefore [9] 25:18 78:15 83:13 104:11 197:9 198:20 259:18 288:15 304:4</p> <p>thermometer [9] 5:21 7:15,24 8:3,5 241:4,9,10 241:20</p> <p>thermometers [3] 7:12 7:14 9:22</p> <p>thesis [2] 351:3 360:16</p> <p>thick [1] 16:14</p> <p>thickness [1] 316:23</p> <p>thinking [8] 47:21 50:9 103:4 124:24 193:18 203:19 281:22 294:11</p> <p>thinks [1] 289:19</p> <p>third [10] 31:12 78:9 86:24 124:21 125:12 168:22 227:25 278:4 285:9 332:6</p> <p>thought [25] 17:7 39:5 61:13 64:10,22 66:14 101:17 154:25 157:16 159:2 187:4 204:1 212:8 232:20 246:10 250:7 275:1,5 302:24 311:17 311:20 314:2 315:4,7 373:12</p> <p>thoughts [1] 44:4</p> <p>thousand [3] 78:8 82:5 121:5</p> <p>thousands [3] 77:21 81:25 336:1</p> <p>three [38] 4:23 9:3 11:3 24:17 35:17 39:8,8 50:18 60:23 77:20 80:8,21</p>
--	---	--	--	---

<p>81:24 99:15 116:21 167:5 167:17,20 169:11,11,16 172:23 175:25 233:23 259:16 265:7,20 266:3 287:21 301:3 306:4,16 306:18 307:17 335:23 337:8 371:10 372:15</p> <p>threw [1] 233:9</p> <p>through [90] 3:3,5,7,8,9 3:10,11,14,15,17,20,21 3:22,23,24,25 18:22 22:8 23:11 24:14 35:16 41:14 60:7 74:16 77:20 80:4,9 102:7,8 103:1 110:10 115:17 131:1 163:14 177:4 220:15 242:4 291:22 300:13,18 301:4 303:16,17,17 306:7 307:6 311:1 313:7 318:6 336:4 337:3,8 346:14,16,17,17 346:18,19,20,21,23,24 346:25 347:1,1,2,3,13 347:15,17,18,19,20,21 347:24,25 348:2,5,6,7,8 348:9,10 349:16 352:10 360:19 361:7 362:15 365:17 369:24</p> <p>throughout [6] 25:12 127:13 338:19 340:8,10 368:4</p> <p>throw [1] 76:7</p> <p>ti [1] 189:19</p> <p>Tilley [3] 55:17 57:12 248:20</p> <p>timed [2] 242:14,16</p> <p>timer [2] 242:25 243:10</p> <p>timers [1] 242:25</p> <p>times [21] 7:7 227:3,4,4 227:8 240:23 242:9 243:17 249:23,25 250:11 282:25 285:12 301:1 304:8 319:21 334:10 335:3 341:5 357:11 363:20</p> <p>timings [1] 242:22</p> <p>tissue [26] 16:13,22 47:11 67:23 179:1 181:6 183:14 196:23,25 197:7,18 228:6 228:6,14 238:23 251:10 252:18 256:22 263:13 274:10,16 281:14,24 316:23 336:6,7</p> <p>title [5] 216:3 255:8 350:12 370:25 373:11</p> <p>titles [1] 349:17</p> <p>today [14] 77:16 91:23 92:2 100:6 113:6 128:25 129:9 131:19 157:13 249:7,9 258:18 322:22 336:6</p> <p>together [11] 50:18 72:25 77:3 94:23 101:7,13 176:13 196:18 219:16 365:9 368:14</p> <p>toll [1] 24:25</p> <p>tomorrow [1] 375:25</p> <p>too [10] 16:14 85:17,18 104:11 168:1,14 240:6</p>	<p>313:20 326:25 369:2</p> <p>took [10] 20:13 195:10 221:23 223:2 290:5,10 296:10 358:19,25 361:14</p> <p>tools [4] 353:22 354:3,6 357:24</p> <p>top [8] 162:23 229:20 230:10 234:3 259:22 276:7 297:25 298:7</p> <p>topple [1] 320:6</p> <p>Torlakovic [2] 204:16 209:2</p> <p>Torlakovic's [1] 214:24</p> <p>total [29] 89:1 96:17 97:1 98:16 99:8,12 119:3 135:12 151:11,16 168:24 169:22 170:21,24 173:11 205:7,9 263:16,20 265:5 265:9 266:11 269:17,18 298:1,1 304:23 306:4 353:8</p> <p>totals [1] 118:18</p> <p>touching [1] 209:7</p> <p>toward [2] 265:6 287:23</p> <p>towards [4] 23:2 27:22 313:18 349:9</p> <p>TQ [1] 351:23</p> <p>TQM [1] 353:8</p> <p>TR [2] 234:7,11</p> <p>track [2] 366:6 368:16</p> <p>tracking [1] 155:25</p> <p>trade [1] 13:11</p> <p>traditionally [1] 357:8</p> <p>train [4] 12:3 214:4 290:12 314:19</p> <p>trained [5] 12:1,9 45:15 213:16 279:22</p> <p>training [18] 4:22 5:7,9 6:3 9:2,3 19:16,20 23:10 24:8,10 42:8 63:2 201:8 213:11,13 290:8 317:3</p> <p>transcribed [2] 305:1 377:9</p> <p>transcript [3] 204:20 313:1 377:3</p> <p>transfer [2] 199:21 200:9</p> <p>transferred [2] 45:12 199:24</p> <p>transition [3] 10:23 76:9 369:23</p> <p>transpired [3] 291:24 292:16 293:3</p> <p>transplantation [1] 67:23</p> <p>transport [2] 55:25 56:19</p> <p>transportation [1] 54:8</p> <p>transported [1] 54:14</p> <p>transporting [1] 56:17</p> <p>treat [3] 126:21 128:20 252:4</p> <p>treated [11] 80:12 126:16 127:25 128:14 138:23 140:21 141:11,17 150:21</p>	<p>251:19 337:22</p> <p>treating [2] 114:5 181:25</p> <p>treatment [29] 77:19,25 112:1,22 113:12 114:12 114:17 136:7 137:7,18 137:20,22 138:7,8 139:17 140:7 141:20 142:10 143:12 144:23 147:15 148:25 149:8 153:21 162:1 182:25 334:21 336:15 337:2</p> <p>trend [3] 367:20 368:1 368:12</p> <p>trending [2] 367:1 368:5</p> <p>trends [4] 157:18 366:9 367:9 369:8</p> <p>trespassed [1] 267:25</p> <p>trial [2] 32:2 33:23</p> <p>tried [1] 163:17</p> <p>Trish [6] 33:7 44:20 310:6,24 311:5 339:22</p> <p>trouble [2] 271:15 365:19</p> <p>troubleshoot [2] 9:11 61:6</p> <p>troubleshooting [8] 8:15,18,20,24 9:5,6,8 12:23</p> <p>true [10] 22:23 92:10,19 179:6 244:14 265:8 266:9 266:9 326:22 377:3</p> <p>truly [1] 337:10</p> <p>trust [1] 78:25</p> <p>try [14] 4:15,20 36:17 73:1 74:5 77:3 89:13 104:5 108:19,22 179:3 256:22 303:14 376:6</p> <p>trying [15] 31:19 40:24 42:2 44:16 45:1 73:8 74:22 112:21 157:13 225:2 251:25 272:11 274:5 353:16 357:12</p> <p>trypsin [19] 225:20,23 226:2,12 234:19 235:2 235:19 236:6,18 237:6 237:10 239:2,6,6,8 245:1 245:4,6,8</p> <p>tumour [9] 26:4,22 42:3 181:3 182:12 183:14 197:22 228:6 264:6</p> <p>tumours [3] 179:24 180:3 301:25</p> <p>turn [4] 240:9 248:21 256:1 296:24</p> <p>turnaround [1] 357:11</p> <p>turned [2] 313:22 314:4</p> <p>turnover [2] 18:4,6</p> <p>turnovers [1] 17:21</p> <p>turns [2] 103:16 281:13</p> <p>twenty [3] 242:14 243:1 301:10</p> <p>twice [2] 84:20 355:6</p> <p>two [59] 5:21 6:11 16:11 19:16 31:23 32:1 35:17 49:25 50:5,15 59:4 66:12 104:8,25,25 105:5 116:25</p>	<p>123:18 134:11 135:7,15 143:15 145:10,17 146:3 146:9 147:2 151:20 162:23 167:17,23 171:12 171:14 174:10 187:4 196:6 199:12,16 200:22 200:25 219:1 233:20 235:1 262:24 263:11 267:3,7 272:15 273:11 277:25 287:23 306:4,16 306:18 307:17 316:1 323:16 365:10 369:21</p> <p>type [17] 10:1 11:13 17:23 62:18 124:8 183:14 183:14,14 350:16 355:9 355:11,12 364:13,19 367:16,24 368:2</p> <p>types [9] 45:9 86:19 125:9 352:9 357:12 363:7 363:8 366:23 367:9</p> <p>typically [1] 138:23</p> <p>typographical [1] 144:1</p> <hr/> <p style="text-align: center;">-U-</p> <hr/> <p>Uh-hm [18] 12:21 65:13 118:24 179:11 186:4 205:11 211:9 223:14 224:14 231:11 238:11 242:18 288:2 300:22 301:9 303:7 305:3 331:15</p> <p>UK [2] 212:17 213:3</p> <p>ultimately [5] 114:11 202:16 203:16,20 328:22</p> <p>ultra [1] 226:9</p> <p>Um-hm [3] 34:2 256:11 267:11</p> <p>unaware [2] 342:13,21</p> <p>unclear [3] 10:22 11:5 34:16</p> <p>uncontroversial [1] 204:2</p> <p>uncover [1] 252:1</p> <p>uncovering [1] 225:4</p> <p>under [21] 26:1,18,19,20 26:21,22 86:23 87:3 88:2 167:21 170:18 173:4 204:5 225:6 230:24 234:19 235:1 248:10 253:24 314:10 334:13</p> <p>understand [24] 19:3 22:14 25:6 27:3 30:24 39:25 40:24 45:11 48:24 52:22 57:21 144:21 179:4 180:18 183:21 184:21 251:17 270:25 271:8 303:13,19 318:11 327:11 333:20</p> <p>understood [7] 42:5 64:16 122:7 136:22 324:1 338:24 339:19</p> <p>undertake [1] 94:17</p> <p>underwent [1] 334:23</p> <p>unfortunately [5] 4:14 97:21 125:3,11 339:7</p> <p>uniform [1] 48:19</p> <p>uniformly [2] 4:25 28:8</p>	<p>unions [1] 214:12</p> <p>unique [2] 184:24 288:7</p> <p>unit [1] 350:5</p> <p>United [1] 311:5</p> <p>university [4] 321:5,13 322:3 348:18</p> <p>unknown [2] 255:16 301:25</p> <p>unmask [1] 228:13</p> <p>unmasking [1] 229:22</p> <p>unmasked [1] 47:25</p> <p>unusual [2] 124:10 209:8</p> <p>up [106] 5:14 11:6 15:24 16:1,5 20:24 21:1,14 22:13 24:16,19 26:12 27:1 29:8,18 36:8 39:14 42:24 43:21 52:21 60:1 60:6,21 73:11,21 80:8 83:4 84:2 86:5 88:10,11 105:8 107:22 110:18 115:24,24 116:2 132:13 138:15 140:23 152:7 162:16 174:14 175:24 184:11 191:1,2 198:19 198:21,24 200:19 201:4 204:22 205:23 208:12 209:2 217:20 227:24 229:7 230:25 237:7 240:9 240:12 241:21 243:2,11 259:13 261:21 273:24 277:20 278:2,15,21 281:6 281:10 292:18 293:6,22 295:13 297:17 298:4 303:15 307:20 308:13,14 310:10,13 313:11 314:19 318:17 319:24 321:21 325:16 346:13 356:23 358:14 362:13 364:8,12 366:13,25 368:1,6,12 369:8 375:25</p> <p>update [1] 268:14</p> <p>updated [2] 283:1 361:25</p> <p>updates [1] 195:14</p> <p>upgrading [1] 28:11</p> <p>ups [1] 28:1</p> <p>used [54] 11:7 12:15,17 13:13 40:6 45:10 46:1 47:9,23,24 48:21 50:5 91:25 104:10,11 152:5 180:1 182:25 183:1 196:14 214:19 225:23 226:10,12,18,23 230:14 231:8 232:13 236:2 237:10,14,24 239:6 239:6,8 240:16 241:25 243:19 245:4,8 252:15 256:12,21 257:3,10,23 268:22 319:2 337:10 338:20 344:10 360:19</p> <p>uses [2] 7:23 210:8</p> <p>using [39] 8:5 11:18 27:18 32:6 33:19 45:23 50:13 71:18 111:2 146:18 146:18 148:21 156:20 179:2 183:17 225:18 227:12 233:11,17 235:19 238:19,19 239:2 245:1</p>
---	---	---	---	--

<p>247:24 248:9 299:4 318:7 338:18 342:1,14 343:17 343:21 353:23,24 368:20 368:22,25 376:6</p> <p>usual [1] 181:11</p> <p>usually [2] 362:14 363:20</p> <p>utilization [3] 351:25 357:24 371:7</p> <p>utilize [1] 354:2</p> <p>utilized [1] 340:16</p> <p>utilizing [1] 342:8</p> <p>utmost [2] 187:1 198:9</p>	<p>290:16 295:11</p> <p>voluntarily [1] 67:8</p> <p>volunteers [1] 257:6</p> <p>VP [1] 363:22</p>	<p>wholeheartedly [1] 317:6</p> <p>Williams [11] 42:22 55:17 57:13 67:5 68:16 228:3,17 248:21 289:3 289:13 290:21</p> <p>win [1] 287:25</p> <p>wish [8] 5:13 38:16 60:5 60:6 64:8 195:23 206:19 268:10</p> <p>wishes [2] 326:9 327:8</p> <p>within [31] 5:15 6:20 9:7 9:11 14:14 20:18 21:14 27:15 28:22 30:18 42:25 73:13 75:11 96:10 98:8 103:4 129:20 162:6 197:4 220:15 249:2 263:13 265:22 290:19 325:17 326:19 331:20 334:9 337:12 362:24 363:13</p> <p>without [2] 62:3 336:18</p> <p>witness [5] 271:3 326:8 327:5 345:1,15</p> <p>witnesses [5] 21:25 309:24 325:11,18 334:4</p> <p>woman [1] 128:16</p> <p>women [1] 326:3</p> <p>wonder [2] 106:23 204:14</p> <p>wondering [10] 77:4 79:25 88:16 99:16 101:12 102:1,10 139:10 141:14 308:25</p> <p>word [9] 26:10,15,18 210:8 214:20 234:19 235:2 271:15 327:2</p> <p>wording [1] 70:18</p> <p>words [2] 85:1 282:20</p> <p>worked [15] 16:17 28:23 196:1,4,5 197:24 198:7 203:10 315:22 317:23 348:23 349:24 350:4,5 363:13</p> <p>worker [1] 350:4</p> <p>workload [3] 60:22 290:16 295:11</p> <p>workplace [1] 19:25</p> <p>works [2] 203:24 361:24</p> <p>workshop [2] 13:13,19</p> <p>workshops [1] 13:9</p> <p>world [2] 116:5 264:22</p> <p>worried [2] 83:17 101:11</p> <p>worthwhile [2] 120:3 376:5</p> <p>WP [2] 330:16,16</p> <p>write [3] 39:13 343:19 350:15</p> <p>writing [13] 67:15 68:16 228:17 259:21,24 260:1 286:25 287:11 293:7 294:2,22 317:19,22</p> <p>written [4] 79:19 233:25 235:15 342:24</p> <p>wrong [5] 74:6,14 185:4 185:9 305:24</p>	<p>wrote [2] 17:13 67:4</p> <hr/> <p style="text-align: center;">-Y-</p> <hr/> <p>year [43] 4:23 6:10 7:10 9:3 14:1 19:14 28:24 119:13,13 120:25 121:14 121:21 122:21,24 158:5 158:10,13 162:22 166:10 166:10 167:20 169:16 171:5,5,8,9 173:18,20 174:14,16,17 199:20 204:25 297:10 319:18,21 329:12 330:5 334:19 350:17 351:5 358:12 366:15</p> <p>year's [1] 337:6</p> <p>year-by-year [1] 171:24</p> <p>year-long [1] 350:23</p> <p>yearly [1] 200:20</p> <p>years [57] 6:11 11:3 20:3 20:4,14 29:12 32:10 37:16 44:5,17 45:1 46:10 50:8 68:12 77:20 80:21 81:25 114:5 116:21 138:22 157:18 167:23 169:23 171:12,14,20 172:25 173:4 179:23 180:13 186:15,24 191:18 191:19 200:24 208:7 219:1 222:21,22,25 223:2 240:17 242:10 256:13 267:3 273:17 278:1,3 301:3 323:17 324:14 334:5,8,23 335:11,23 337:8</p> <p>yesterday [8] 25:4 59:3 72:23 77:11 79:16 99:5 152:10 214:18</p> <p>yet [6] 147:21 203:4 270:10 273:14 303:7 370:1</p> <p>yield [1] 273:12</p> <p>yielded [1] 185:13</p> <p>yields [2] 270:4,5</p> <p>yourself [10] 69:25 76:4 84:12,14 205:24 248:23 276:8,13 291:22 348:15</p> <p>yourselves [1] 63:22</p>	<p>zeros [3] 133:9 171:21 266:9</p>
<hr/> <p style="text-align: center;">-V-</p> <hr/> <p>vacations [1] 294:1</p> <p>valid [2] 269:22 272:2</p> <p>validated [1] 248:8</p> <p>validating [1] 33:2</p> <p>validation [4] 33:10 247:21 341:3,9</p> <p>value [6] 33:4 95:25 171:4,14,23 334:14</p> <p>values [2] 39:14 282:10</p> <p>valve [1] 368:21</p> <p>variables [1] 199:4</p> <p>various [10] 11:5 28:1 39:15 114:5 140:5 195:9 291:16 334:4 349:16 367:4</p> <p>vary [1] 282:14</p> <p>Ventana [35] 7:18 11:6 33:9 71:6,15,17 85:13 85:17 87:16 89:7 162:25 167:16,21 168:24 169:14 172:4,25 173:5,11,20,23 174:7,8,16,22 175:7 237:11 246:18,21 247:2 247:14 248:3,6,15 290:19</p> <p>Ventanas [1] 88:6</p> <p>verified [3] 153:12 275:10 301:4</p> <p>verifies [1] 7:15</p> <p>verify [8] 6:8 151:7 190:12 192:10 209:20 242:12 281:9 340:19</p> <p>Vern [3] 186:1 199:8,15</p> <p>version [2] 40:8 368:25</p> <p>vessel [1] 231:2</p> <p>vice [2] 19:13 20:7</p> <p>view [12] 17:25 27:11 33:18,21 60:17 61:11 83:11 120:2 283:6 284:8 289:21 323:25</p> <p>viewed [4] 30:1 83:13 334:8,14</p> <p>views [1] 286:24</p> <p>visible [1] 225:6</p> <p>vision [1] 337:7</p> <p>voiced [1] 71:1</p> <p>volume [3] 206:1 230:9 230:16</p> <p>volumes [3] 205:16</p>	<hr/> <p style="text-align: center;">-W-</p> <hr/> <p>Wadden [3] 216:12,15 216:23</p> <p>wait [3] 240:10 357:11 373:11</p> <p>wake [1] 308:23</p> <p>walk [2] 365:16,16</p> <p>Wang [4] 10:25 11:12 257:3,11</p> <p>wanting [2] 63:3 281:22</p> <p>wants [1] 304:15</p> <p>Washington [1] 323:20</p> <p>watched [1] 242:4</p> <p>watching [1] 203:9</p> <p>water [8] 50:3,14,17,17 230:23,24 231:1,2</p> <p>waterbath [13] 229:6,9 232:3,8,22 233:4,11 238:9,14,16,19 239:4,19</p> <p>Waterford [9] 348:21 349:1,24 350:8 364:10 369:22 370:4,16,16</p> <p>ways [2] 197:12 256:9</p> <p>weak [13] 83:13 164:23 164:25 165:8,11,18,21 166:16 168:19 170:8 267:4 269:5 330:19</p> <p>week [6] 13:6 19:18 31:18 279:21 324:9 337:5</p> <p>weekend [2] 255:7,7</p> <p>weekly [1] 162:14</p> <p>weeks [3] 110:3 286:21 344:20</p> <p>Wegrzynowski [7] 7:17 34:11 43:1,2 214:18 317:7 339:22</p> <p>Wegrzynowski's [3] 5:14 33:1 63:13</p> <p>weight [1] 326:16</p> <p>welcome [2] 72:3 177:13</p> <p>well-established [2] 32:3 33:25</p> <p>Welsh [10] 12:1 45:13 45:17,21 186:20 208:5 208:21 277:24 278:5 341:18</p> <p>Western [2] 1:16 121:7</p> <p>whatsoever [1] 266:15</p> <p>Whelan [5] 186:1 199:8 199:15,20 319:3</p> <p>whereas [3] 135:11 179:21 182:12</p> <p>whichever [1] 341:11</p> <p>whole [19] 25:13 33:2 43:15,21 54:24 62:21 63:21 66:1 71:22 150:9 153:23 163:14 170:22 194:17 205:8 303:4 306:7 337:4 375:20</p>	<hr/> <p style="text-align: center;">-Z-</p> <hr/> <p>zero [97] 34:20,20,24,24 41:17,17,24,24 42:9 84:19,19 92:12,12 127:17 127:22,22,24 128:14,14 129:2,6,6 131:3,3,11,12 131:14,14 134:15,15,17 134:17,19,20,20,23,23 134:24,25 135:1,1,2,4,5 135:5,10,10,14,14,15,15 135:15,15,15 137:12,12 137:16,16,21,21 139:3,3 139:3,3,4,4 140:24,24 141:9,9,23,24 142:13,13 142:15,15 143:3,3 144:7 144:7,9,9 145:10,19,21 146:3,11,12,12 171:21 263:10,10,22,22 266:9 269:6 331:12</p>		