

COMMISSION OF INQUIRY  
ON HORMONE RECEPTOR TESTING

BEFORE THE HONOURABLE JUSTICE CAMERON--COMMISSIONER

October 22, 2008

Appearances:

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

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

Rolf Pritchard. . . . . Her Majesty in Right of NL

Peter Browne, Q.C./Jane Hennebury . . . Doctors Kara Laing et al

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

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

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

LIST OF EXHIBITS

EXHIBITS C-0276 AND P-3468 . . . . . Pg. 295

TABLE OF CONTENTS

MS. HEATHER PREDHAM--RESUMES THE STAND

Examination by Sandra Chaytor, Q.C.--Cont'd . . . . Pgs. 4-- 271

Examination by Blair Pritchett . . . . . Pgs. 271-- 277

Examination by Jennifer Newbury . . . . . Pgs. 277-- 388

Examination by Chesley Crosbie, Q.C. . . . . Pgs. 388-- 425

Examination by Daniel Simmons . . . . . Pgs. 425-- 455

Examination by The Commissioner . . . . . Pgs. 455-- 457

Certificate

Page 4

1 THE COMMISSIONER:

2 Q. Please be seated. Ms. Chaytor?

3 MS. HEATHER PREDHAM, RESUMES STAND, EXAMINATION BY SANDRA

4 CHAYTOR, Q.C. (CONT'D)

5 CHAYTOR, Q.C.:

6 Q. Good morning, Commissioner. Good morning, Ms.

7 Predham.

8 MS. PREDHAM:

9 A. Good morning.

10 CHAYTOR, Q.C.:

11 Q. If we could have, please, 3039? Ms. Predham,

12 this is the e-mail that I showed you yesterday

13 between yourself and Ms. Elliott and it

14 appears to be the first of the e-mails we have

15 between you regarding the briefing note in

16 August 2006, and you'll note it says "find the

17 note attached. I made the changes to the

18 first part." So do I understand that there

19 would have been an earlier version of this?

20 MS. PREDHAM:

21 A. There may have been. Ms. Elliott tends to--

22 she prints it out and works off that, or you

23 know, she would have--I could have printed it

24 out and brought it up to her before she went

25 home, because obviously she's home at this

Page 5

1 point, and but that's, she tends to work on  
 2 that--in handwriting, writing on something,  
 3 rather than bringing things back and forth  
 4 with e-mail.  
 5 CHAYTOR, Q.C.:  
 6 Q. And do you have any recollection as to what  
 7 the changes would have been to the first part?  
 8 What would have been added or revised?  
 9 MS. PREDHAM:  
 10 A. No, I would think the first part would be the  
 11 first two sentences up at the top.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay.  
 14 MS. PREDHAM:  
 15 A. That's what I would refer to as the first  
 16 part, you know, and -  
 17 CHAYTOR, Q.C.:  
 18 Q. Meaning this here, "based on the information,  
 19 the total patients that were sent"?  
 20 MS. PREDHAM:  
 21 A. Yes, I have no idea what they could be though.  
 22 CHAYTOR, Q.C.:  
 23 Q. Now I think that probably, if we look back at  
 24 0815, it certainly starts off the same, as you  
 25 recall the briefing note that you sent to the-

Page 6

1 -or you prepared for the Board. 0815, please,  
 2 Registrar? Page two of this one. It's the  
 3 one that you prepared earlier for the  
 4 Department.  
 5 MS. PREDHAM:  
 6 A. Right, and maybe it's the--maybe it's taking  
 7 out that part. Maybe it's just the way I  
 8 reworded it.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay. So you may have been using or starting  
 11 with this version?  
 12 MS. PREDHAM:  
 13 A. I would say, knowing the way that I work, I  
 14 probably would start with that and update it.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay, and back, please, to 3039? And we'll  
 17 see, of course, on this version then you've  
 18 included a chart which breaks down according  
 19 to the various regions.  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. So this appears to be new from what was done  
 24 before, this part here, and if we go back to  
 25 your e-mail, you ask her "how do you want me

Page 7

1 to address it at the beginning?" and you'll  
 2 see that you've left blank to. So I take it  
 3 you're wondering who this is going to.  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. Did you ever get an answer to that question?  
 8 MS. PREDHAM:  
 9 A. I must have, if it's addressed towards the end  
 10 for--but actually, I think, if my memory  
 11 serves me from yesterday, I think I only said  
 12 that it was prepared by me and it wasn't to  
 13 anybody.  
 14 CHAYTOR, Q.C.:  
 15 Q. Yes. So as you're going through this and  
 16 drafting this information, you're having  
 17 communication, I take it, back and forth with  
 18 Ms. Elliott?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. And she's providing you with answers to some  
 23 of these questions?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 8

1 CHAYTOR, Q.C.:  
 2 Q. And then, please, if we look at P-1447?  
 3 Actually, sorry, first, 3042. This is the  
 4 version that, on April 11th, you send to Ms.  
 5 Pilgrim, and by then, you've filled in the  
 6 beginning to say "prepared by"?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay. Then if we look at 1447, please? At  
 11 close to two p.m. on the same day, then you  
 12 send the briefing note or the draft that  
 13 you've prepared to Moira Hennessey and you  
 14 copy it to Ms. Pilgrim and Ms. Elliott.  
 15 "Please find the briefing note as attached.  
 16 I've left it draft as Dr. Williams and Dr.  
 17 Denic have not seen it as yet. If you have  
 18 any questions, please do not hesitate to  
 19 contact me." And you'll see this is what  
 20 you've sent to her, and what did you mean by  
 21 you've left it draft because Dr. Williams and  
 22 Dr. Denic hadn't seen it?  
 23 MS. PREDHAM:  
 24 A. I would assume if they had any changes, then  
 25 I'd have to make changes to that, and I guess,

Page 9

1 I was saying it wasn't signed off with that.  
 2 I must say, last night, I was--I felt bad that  
 3 I can't remember anything about that. So I  
 4 went through my notes trying to see if I  
 5 could--you know, for that period of time, if I  
 6 could--you know how your memory goes, if you  
 7 think of one thing, maybe you can think of  
 8 another, and I was thinking while I was doing  
 9 that, like it was an odd note to end up going  
 10 to the Minister when you look at the one the  
 11 fall before, and of course, I never realized  
 12 where this went until this process had  
 13 occurred, because the other one was, you know,  
 14 formatted a certain way and everybody had seen  
 15 it and had feedback on it. So I can't  
 16 remember. I certainly didn't put the same  
 17 weight to it as I did the one the previous  
 18 November, and I really have no--there was  
 19 nothing that twiggged my memory.  
 20 But during that period of time, as I've  
 21 mentioned about the context, things that  
 22 happened that August, I realized when I was  
 23 going through my notes, I've--the things that  
 24 have happened that were going on at the same  
 25 time, I've been interviewed by the police,

Page 10

1 I've been interviewed by the Child Youth  
 2 Advocate. I've been interviewed by  
 3 professional organization, and I'm going to be  
 4 pending to appear at their disciplinary board,  
 5 and I've been at an arbitration hearing, all  
 6 for things that happened in August 2006. So I  
 7 don't think my attention was on this. I  
 8 certainly didn't see it, at the time, as a  
 9 briefing note to the Minister, and really, I  
 10 have no memory, other than what I'm seeing  
 11 here.  
 12 CHAYTOR, Q.C.:  
 13 Q. And when you say you didn't give it the same  
 14 weight that you gave the other briefing note,  
 15 what you're saying is that you don't think you  
 16 paid the same attention to it -  
 17 MS. PREDHAM:  
 18 A. I would have paid the -  
 19 CHAYTOR, Q.C.:  
 20 Q. - because of other things that were going on?  
 21 MS. PREDHAM:  
 22 A. No, no, I would have paid the same attention  
 23 to it, but I didn't--it was just something I  
 24 had to do. It wasn't--you know, it was just  
 25 another task that I had to do and I didn't

Page 11

1 focus in on it.  
 2 CHAYTOR, Q.C.:  
 3 Q. And that--did that ever change though in your  
 4 work existence, the whole time you're dealing  
 5 with this, in terms of your having to deal  
 6 with many tasks and serious issues at the same  
 7 time?  
 8 MS. PREDHAM:  
 9 A. It was more intense from the end of '05 onto  
 10 the beginning of '07. It was much more  
 11 intense.  
 12 CHAYTOR, Q.C.:  
 13 Q. Right on through this period?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes. So what do you mean by you didn't give  
 18 the same weight to it as you had the one the  
 19 end of July?  
 20 MS. PREDHAM:  
 21 A. Well, I didn't see it as a--you know, this was  
 22 an information document to--and I'm assuming  
 23 why I can't remember anything, you know, and  
 24 really I shouldn't possibly speculate, but I'm  
 25 just trying to understand why I can't remember

Page 12

1 anything about this briefing note.  
 2 CHAYTOR, Q.C.:  
 3 Q. Yes, okay, and of course, you knew it was  
 4 going to the Minister, at least, because it's  
 5 going to Moira Hennessey?  
 6 MS. PREDHAM:  
 7 A. I may--I probably never thought that through.  
 8 All I knew, it was going to Ms. Hennessey.  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay. Did you receive any feedback or did you  
 11 send it on to Dr. Williams and Dr. Denic, and  
 12 if so, did you receive any feedback from them?  
 13 MS. PREDHAM:  
 14 A. I don't recall. I would have sent it on  
 15 obviously because I said that there, I was  
 16 going to do that, but I don't remember  
 17 anything about it.  
 18 CHAYTOR, Q.C.:  
 19 Q. And do you--did you have any subsequent  
 20 conversation then with Ms. Hennessey about the  
 21 note?  
 22 MS. PREDHAM:  
 23 A. I don't remember speaking to her. The only  
 24 one I remember speaking to is Ms. McCormack  
 25 and that's only a vague memory.

Page 13

1 CHAYTOR, Q.C.:

2 Q. And then did you say you don't recall ever

3 hearing back from Ms. Hennessey to say "well,

4 can we now deal with this? Can it be

5 something other than draft? Have you got the

6 approval with Dr. Williams?" You don't recall

7 any discussion along those lines?

8 MS. PREDHAM:

9 A. Nothing.

10 CHAYTOR, Q.C.:

11 Q. If we could have, please, P-0820? And this is

12 an e-mail exchange between Ms. McCormack and

13 Ms. Hennessey and it originates with Ms.

14 McCormack had some questions. It appears Ms.

15 Hennessey is out of town and she writes a

16 series of questions. It says "I have received

17 the briefing note from Yvonne, as you

18 directed. I still have a few questions," and

19 she has a question about the panel, questions

20 about the 28 patients whose test results were

21 confirmed negative by the panel. "Thirdly,

22 the patients who ER/PR status changed from

23 negative to positive, 208. With no treatment

24 recommendations, the comments section advises

25 some of these patients were considered low

Page 14

1 risk," and she goes on from there and asks

2 "does this mean these patients all have

3 metastatic disease or do we know how many of

4 the 208 do?" She has a question of the 56

5 patients with DCIS and "thanks for any

6 clarification you can provide" and she made

7 the other changes that Ms. Hennessey has

8 recommended.

9 And then there's a reply on August 16th

10 from Ms. Hennessey to those questions and she

11 indicates "there are 39 patients confirmed

12 with DCIS and 14 still under review. I don't

13 know when the reviews will be completed or if

14 these patients have been notified. If you

15 need this info today, you can check with

16 Heather Predham directly." And where would

17 Ms. Hennessey get the 39 patients confirmed

18 with DCIS and 14 still under review?

19 MS. PREDHAM:

20 A. Unless it's in my briefing note, I would

21 assume that I must have told her, but I'm not

22 sure.

23 CHAYTOR, Q.C.:

24 Q. And you'll see then, this is how Ms. Hennessey

25 apparently has done some revisions to the

Page 15

1 table that you had provided, and you'll

2 recall, in terms of dealing with the deceased,

3 you had, I believe, broken down the number of

4 deceased in what you had provided.

5 MS. PREDHAM:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. Yes, you had a paragraph which indicated that

9 101 of them had been retested?

10 MS. PREDHAM:

11 A. Yes.

12 CHAYTOR, Q.C.:

13 Q. And she's put in here 176 and refers to the

14 ethics review, which was in your note. "A

15 public statement will be made at the end of

16 the ER/PR review that if family members want

17 the results, they can contact Eastern Health."

18 So Ms. Hennessey is indicating to Ms.

19 McCormack, if she does need any further

20 information, then she can get it from you, and

21 you do recall having had--you have a vague

22 recollection of some discussion with Ms.

23 McCormack?

24 MS. PREDHAM:

25 A. Yes.

Page 16

1 CHAYTOR, Q.C.:

2 Q. Do you recall what was discussed? What issues

3 did she come back that she needed further

4 clarification about?

5 MS. PREDHAM:

6 A. Really all I can remember is that she didn't

7 have a lot of knowledge about the issue as a

8 whole, and I was walking her through that and

9 that's the extent of my memory.

10 CHAYTOR, Q.C.:

11 Q. So for example, here she had questions

12 regarding some of the--like the role of the

13 panel, do you recall did you discuss the role

14 of the panel with her?

15 MS. PREDHAM:

16 A. I may have. Like I said, I only remember, you

17 know, that feeling that, you know, she didn't

18 know much about the issue and that I had to go

19 back and explain estrogen receptors, you know,

20 the fundamentals.

21 CHAYTOR, Q.C.:

22 Q. And do you recall whether or not you had to

23 clarify any numbers with her?

24 MS. PREDHAM:

25 A. I don't recall.

Page 17

1 CHAYTOR, Q.C.:

2 Q. And do you recall whether or not you discussed

3 with her the external reviews and the stage at

4 which the external reviews were?

5 MS. PREDHAM:

6 A. Like I said, that's the only memory I have of

7 it.

8 CHAYTOR, Q.C.:

9 Q. So you have no recollection of that either?

10 MS. PREDHAM:

11 A. No.

12 CHAYTOR, Q.C.:

13 Q. Okay, and if we could have, please, P-0192?

14 And Ms. McCormack again is writing to Ms.

15 Hennessey and this is on August 17th. "I was

16 able to clarify the information on the

17 Newfoundland panel and their role with Heather

18 Predham." So it appears that you've had a

19 conversation with her on that issue. "I

20 included an extra bullet under background,

21 last bullet, to describe the Newfoundland

22 Labrador panel and their role. In the

23 introduction to the chart, I made reference

24 again to the panel," and in her opinion, the

25 note is now clear, and "with your approval,

Page 18

1 I'll forward to Gary," and she's just

2 directing here that it be put into Eastern's

3 directory within their system. And you'll see

4 that here's what it now looks like, and

5 there's background and she's referred to the

6 extra bullet on the panel, and then she refers

7 again to the panel in putting forward the

8 numbers, and most of these numbers, of course,

9 are what were provided by you, with the

10 description, with the exception, as I've

11 pointed out to you, about the 176 deceased and

12 no reference to the 101.

13 MS. PREDHAM:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. I believe otherwise it's fairly standard, and

17 then "currently there are two legal claims

18 that have been filed," and there's reference

19 to Verna Doucette and Michelle Hanlon's

20 claims. Do you recall discussion with Ms.

21 McCormack around that?

22 MS. PREDHAM:

23 A. No. Like I said, I only have this vague

24 memory of that phone call.

25 CHAYTOR, Q.C.:

Page 19

1 Q. And you'll see then, there's a section of

2 impacts of treatment with Tamoxifen. Do you

3 recall any discussion about the benefits of

4 Tamoxifen or the purpose of Tamoxifen?

5 MS. PREDHAM:

6 A. No, and I wouldn't be able to tell her that

7 detail either.

8 CHAYTOR, Q.C.:

9 Q. Okay, and reasons for the erroneous results

10 and steps taken to prevent recurrence. Do you

11 recall any discussion around that?

12 MS. PREDHAM:

13 A. No.

14 CHAYTOR, Q.C.:

15 Q. And then action required, just says "should

16 the Premier need further details, Eastern

17 Health, as well as their legal counsel, will

18 be available." Do you recall advising either

19 Ms. McCormack or Ms. Hennessey that Eastern

20 Health or its solicitor could make themselves

21 available?

22 MS. PREDHAM:

23 A. Absolutely not, but I only have a vague memory

24 of that phone call, but I certainly wouldn't

25 say that.

Page 20

1 CHAYTOR, Q.C.:

2 Q. Okay, and this is an earlier draft. I'll take

3 you to the final version. Was this draft

4 shared with you?

5 MS. PREDHAM:

6 A. No.

7 CHAYTOR, Q.C.:

8 Q. And if we look at page six of this document,

9 there's another e-mail exchange between Ms.

10 McCormack and Ms. Hennessey and she says

11 "attached is the final copy of the above" and

12 you'll see that it's now August 18th. So

13 "attached is the final copy of the above

14 briefing note, if you approve of same. I had

15 to go back to Heather to ask how many women

16 were most impacted by the change in status of

17 the ER/PR receptor testing." So it appears

18 that there's been another discussion with Ms.

19 McCormack, and do you recall that, having at

20 least a second discussion with her?

21 MS. PREDHAM:

22 A. Again, I only have a vague memory of talking

23 to her and there's nothing else. I can't

24 remember if it was once or twice.

25 CHAYTOR, Q.C.:

Page 21

1 Q. And so do you recall this question, that she  
 2 goes back to ask you how many women were most  
 3 impacted?  
 4 MS. PREDHAM:  
 5 A. I don't recall the question, but looking back  
 6 at the briefing note, I can see where 22 would  
 7 come from.  
 8 CHAYTOR, Q.C.:  
 9 Q. So you have no doubt that you would have  
 10 provided her with that number?  
 11 MS. PREDHAM:  
 12 A. If she had called and asked me who were the  
 13 most impacted, I would have referenced those  
 14 two groups, because that's what I felt were  
 15 the most impacted people.  
 16 CHAYTOR, Q.C.:  
 17 Q. And those two groups being the 13 and the  
 18 nine?  
 19 MS. PREDHAM:  
 20 A. And the nine.  
 21 CHAYTOR, Q.C.:  
 22 Q. "She gave me the number 22 as indicated on the  
 23 third page of the briefing note. Gary also  
 24 wanted to know how many were likely to  
 25 initiate legal action and according to

Page 22

1 Heather, any or all of the 939 women or their  
 2 families could so." Do you recall having a  
 3 discussion with her then around that point?  
 4 MS. PREDHAM:  
 5 A. No.  
 6 CHAYTOR, Q.C.:  
 7 Q. And is that likely something that you would  
 8 have said?  
 9 MS. PREDHAM:  
 10 A. Well, I could have said that. Well, it's  
 11 true. So I could have said that.  
 12 CHAYTOR, Q.C.:  
 13 Q. And "exact numbers would not be known at this  
 14 time. She explained that even if the results  
 15 were correct from the initial testing to the  
 16 retesting at Mount Sinai, the stress caused to  
 17 some women and families by knowing they were  
 18 being retested, how long they had to wait for  
 19 information, etcetera, could be a basis to  
 20 initiate an action or to participate in the  
 21 class action, if that's the way that this  
 22 proceeds." So the idea that people could  
 23 initiate actions based on the stress caused to  
 24 them, that's something that you would have  
 25 been cognizant of that could happen?

Page 23

1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And then if we look at page ten of this,  
 5 you'll see that this is what she's indicating  
 6 at that point is to be the final draft, and on  
 7 page ten, in the summary, there's reference  
 8 now to the "legal action initiated by Mrs.  
 9 Myrtle Lewis as a result of misdiagnosis and  
 10 is not linked to the problems described in  
 11 this note with the ER/PR receptor test which  
 12 had to be repeated." Would you have been the  
 13 source of that information to the Government?  
 14 MS. PREDHAM:  
 15 A. I may have been. Like I said, I can't  
 16 remember any details of that conversation,  
 17 just the fact that I talked to her, but I may  
 18 have been.  
 19 CHAYTOR, Q.C.:  
 20 Q. And I believe we saw an e-mail earlier that we  
 21 referred to yesterday, where you were  
 22 distinguishing between the action by Ms.  
 23 Lewis.  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 24

1 CHAYTOR, Q.C.:  
 2 Q. And that of the ER/PR.  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. So that sounds consistent with that. "Eastern  
 7 Health advises 22 women were greatly impacted  
 8 by the change in status of the ER/PR receptor  
 9 tests. These women had changes in the  
 10 progress of their disease from the initial  
 11 confirmation of the disease and the beginning  
 12 of their treatment to the retesting done at  
 13 Mount Sinai." And does that sound consistent  
 14 with if you had been asked the question of how  
 15 many were most impacted? Is that the type of  
 16 answer you would have given?  
 17 MS. PREDHAM:  
 18 A. Well, I would come up with 22, but that's not  
 19 really the way that I would have put it, and  
 20 there's no period after Sinai. It looks like  
 21 there should be more to it, because that's  
 22 only one aspect of it.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay, so what else would you have added?  
 25 MS. PREDHAM:

Page 25

1 A. Well, you know, there was two people, people  
 2 who were already on Tamoxifen because of  
 3 metastases and other ones who the panel felt  
 4 that there was a progression of the disease in  
 5 that time period, and of course, like 22  
 6 wasn't an all-inclusive number. It was more  
 7 of a sense. It was only the ones that the  
 8 panel had verbalized that.  
 9 CHAYTOR, Q.C.:  
 10 Q. And I know you have no recollection though of  
 11 your discussion with Ms. McCormack, but would  
 12 you have made that clear to her, do you think,  
 13 that "I'm not sure of this number"?  
 14 MS. PREDHAM:  
 15 A. Well, my usual practice, as I went forward,  
 16 was always to have that. There was always  
 17 provisos and whenever I talked about those two  
 18 groups, I always said that that was--you know,  
 19 it wasn't a validated number. It wasn't  
 20 anything that the panel set out to say, but it  
 21 was something that was in that discussion. So  
 22 whenever I discussed those two criteria,  
 23 that's usually the context that I put it in.  
 24 CHAYTOR, Q.C.:  
 25 Q. So I'm just wondering then, in terms of her

Page 26

1 taking away from it, 22 women were greatly  
 2 impacted, are you saying you would have--if  
 3 this had been shared with you, you would have  
 4 sought to clarify that further?  
 5 MS. PREDHAM:  
 6 A. Well, as long as she understood that that  
 7 wasn't--you know, I wasn't saying there was  
 8 only 22. I was saying that we identified 22,  
 9 but also the second part of that doesn't fully  
 10 describe it to what I would normally say.  
 11 CHAYTOR, Q.C.:  
 12 Q. And in coming up with the 22, were you--did  
 13 you go back--this is now August of 2006. Did  
 14 you go back and consult with any of the  
 15 oncologists to let them know that, "This is a  
 16 question that is coming from the government  
 17 and how can I best answer this, I've taken  
 18 notes as we've gone along and when people make  
 19 comments about this person is impacted or this  
 20 person has a metastases, I've made those  
 21 notes", and that's what we understood from  
 22 your evidence is how you -  
 23 MS. PREDHAM:  
 24 A. Uh-hm.  
 25 CHAYTOR, Q.C.:

Page 27

1 Q. Were keeping track, but you go back then and  
 2 ask any oncologists how can I assess this?  
 3 MS. PREDHAM:  
 4 A. No, I did not.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay. So nobody assisted you in coming up  
 7 with this at this point?  
 8 MS. PREDHAM:  
 9 A. No.  
 10 CHAYTOR, Q.C.:  
 11 Q. And you, yourself, didn't go back and do any  
 12 review of your own notes to see if there were  
 13 others?  
 14 MS. PREDHAM:  
 15 A. No.  
 16 CHAYTOR, Q.C.:  
 17 Q. And in terms of saying 22 women being greatly  
 18 impacted, do you recall did you ever use the  
 19 word "greatly" or is that a word -  
 20 MS. PREDHAM:  
 21 A. Well, I would have had--I would have had, I  
 22 guess, an adverb to describe it because, you  
 23 know, they were all impacted, so there would  
 24 have been some differentiation because that's  
 25 what I was trying to do with the 22 number,

Page 28

1 was to differentiate it, so I'd have to have  
 2 some word to describe a more intense level of  
 3 being impacted.  
 4 CHAYTOR, Q.C.:  
 5 Q. So it wasn't your opinion that it was only 22  
 6 people impacted? If you're using the number  
 7 22, you're seeing those as potentially the  
 8 ones that are most impacted?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And if we could have, please, P-2618. This is  
 13 an e-mail exchange then between myself and Mr.  
 14 Simmons, and Mr. Simmons--it starts with a  
 15 question, I believe, from myself on August  
 16 18th, 2008, and "Could you please ask Heather  
 17 Predham the follow for us. In the August  
 18 18th, 2006, briefing note for the  
 19 premier/cabinet secretariat, how were the 22  
 20 people noted to have been impacted identified,  
 21 what criteria was used; also please provide a  
 22 list of their names". "Heather Predham does  
 23 remember a call from Marilyn Predham (sic.)  
 24 after she sent the breakdown of retest results  
 25 to the department, but she does not recall any

Page 29

1 detail of what they discussed about the  
 2 patients who were most impacted by changes in  
 3 test results. From looking back at the table  
 4 Heather prepared on August 11th", which is P-  
 5 1447, and we've already looked at that, "she  
 6 thinks it is most likely that Ms. McCormack  
 7 questioned her about which groups were likely  
 8 to be most greatly impacted, and that Heather  
 9 identified two groups. One was the 13 who had  
 10 changed from negative to positive, who had not  
 11 been placed on Tamoxifen for their original  
 12 disease, but who had been placed on Tamoxifen  
 13 because they had developed metastatic disease  
 14 before the retesting. The other was the nine  
 15 who had a change from negative to positive for  
 16 whom the panel recommended that they be placed  
 17 on Tamoxifen and whose disease had progressed  
 18 in the interim. These 22 patients were ones  
 19 with change results who had not received  
 20 Tamoxifen when they otherwise might have, and  
 21 whose disease had progressed. While it is  
 22 impossible to say whether their disease would  
 23 or would not have progressed had they received  
 24 Tamoxifen earlier, Heather says that she would  
 25 have identified them as the ones with the

Page 30

1 greatest likelihood of having been impacted.  
 2 Heather says that she cannot put her hands  
 3 immediately on the list of 13 and 9, it may be  
 4 among her materials. Alternatively, it may be  
 5 able to be reconstructed. Do you want us to  
 6 follow up". "Yes, please, that would be  
 7 helpful, and also could Heather explain the  
 8 distinction between the 13 and the 9, what  
 9 does it mean that the disease had progressed  
 10 in the 9, did they have more than one ER/PR  
 11 test conducted prior to the retesting at Mount  
 12 Sinai". The answer back is, and this looks  
 13 like it may be cut from an answer that you  
 14 gave to Mr. Simmons, is that correct?  
 15 MS. PREDHAM:  
 16 A. I do believe so.  
 17 CHAYTOR, Q.C.:  
 18 Q. It's in quotation marks there and it's a  
 19 different type--different colour type, and the  
 20 answer that comes back is, "The 13 patients  
 21 were patients who were diagnosed with breast  
 22 cancer and were considered ER/PR negative.  
 23 Because of that, Tamoxifen was not in their  
 24 treatment plan at that time. Upon retesting  
 25 of that original specimen, there was a change

Page 31

1 which would cause them to be considered  
 2 positive now. When the panel reviewed their  
 3 charts, it was determined that during the time  
 4 period between the original test and the  
 5 retest, they had been diagnosed with a  
 6 recurrence -  
 7 MS. PREDHAM:  
 8 A. Metastases.  
 9 CHAYTOR, Q.C.:  
 10 Q. "Metastases", thank you, "which was then  
 11 treated with Tamoxifen. So from a  
 12 categorizing point of view, they would be in a  
 13 group with no recommendations. However, it  
 14 was clear from the conversation at the panel  
 15 table that earlier treatment with Tamoxifen  
 16 may have had an impact". First of all, I just  
 17 want to stop there. So did those 13 all have  
 18 metastases, or were they also in the--included  
 19 in the 13, a recurrence of their original  
 20 disease?  
 21 MS. PREDHAM:  
 22 A. I can't remember right now, but they must  
 23 have. If I put that there, I guess I wasn't  
 24 clear. I hadn't gone back at that point to  
 25 identify the 13, so I just wanted to make sure

Page 32

1 I didn't say they were all metastases.  
 2 CHAYTOR, Q.C.:  
 3 Q. And in going back and getting this answer for  
 4 us, what did you have to do? Did you have a  
 5 list of the patients or what did you consult?  
 6 MS. PREDHAM:  
 7 A. I had to go back through my notes that I took  
 8 during the panelling and verify it through  
 9 there. I didn't have a list. I couldn't find  
 10 a list with 13 and 9 on it. I could find a  
 11 list with so many on it, but not 13 and 9.  
 12 CHAYTOR, Q.C.:  
 13 Q. And were you able to determine whether or not  
 14 amongst the 22 that you provided, any of the  
 15 patients you provided were, in fact, deceased  
 16 at the time that they were panelled?  
 17 MS. PREDHAM:  
 18 A. I can't remember if--I can't remember. I  
 19 didn't think I did.  
 20 CHAYTOR, Q.C.:  
 21 Q. And if there was a patient who was deceased at  
 22 the time, that wouldn't have been captured in  
 23 your notes?  
 24 MS. PREDHAM:  
 25 A. Well, it should be, unless we discovered after



Page 33

1 they were panelling that they were deceased.  
 2 CHAYTOR, Q.C.:  
 3 Q. So it could be that a patient ended up in the  
 4 22, and the patient was deceased, but at the  
 5 time the panel is discussing this patient,  
 6 they didn't realize that?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. "The other nine were patients who were also  
 11 diagnosed with breast cancer and were  
 12 considered ER/PR negative, and again Tamoxifen  
 13 was not in their treatment plan at that time.  
 14 Upon retesting of that original specimen,  
 15 there was a change which would cause them to  
 16 be considered positive now. When the panel  
 17 reviewed their charts, it was determined that  
 18 during the time period between the original  
 19 test and the retest, their disease had  
 20 progressed. Not, I guess, significantly  
 21 enough to warrant being placed on adjuvant  
 22 therapy, but enough that the clinicians around  
 23 the table discussed that the lack of Tamoxifen  
 24 may have had an impact. From a categorizing  
 25 point of view, they would be in the group with

Page 34

1 a recommendation for treatment", and what did  
 2 that mean, what do you recall being discussed  
 3 about their disease hadn't progressed  
 4 significantly enough for them to--warrant them  
 5 having been placed on adjuvant therapy?  
 6 MS. PREDHAM:  
 7 A. I was--I'm guessing there that it hadn't--  
 8 disease progressed enough, and, you know, at  
 9 this point, I mean, I've only known about this  
 10 for the past three years, I don't know much  
 11 about cancer therapy. This was my listening  
 12 to people around the table.  
 13 CHAYTOR, Q.C.:  
 14 Q. And referring without, of course, mentioning  
 15 the name, the one patient that was deceased,  
 16 you gave us this list of names we--go back, I  
 17 believe, and look for--please provide the  
 18 names of the 22 and you're working on it. So  
 19 you were able to go back through your notes,  
 20 and those would be the notes that--your  
 21 spreadsheets, you're at the panel meetings,  
 22 and you record impacted by some of the names  
 23 of those people?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 35

1 CHAYTOR, Q.C.:  
 2 Q. So if were to sit with you or try and  
 3 reconstruct that, you'd be able to point out  
 4 the 22 references where people are impacted?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And then did you actually have to pull the  
 9 charts to reconstruct this?  
 10 MS. PREDHAM:  
 11 A. No, I didn't then. I just went back to--I  
 12 just wanted to have the information I had at  
 13 the time. I didn't pull any charts or look at  
 14 anything else.  
 15 CHAYTOR, Q.C.:  
 16 Q. And how did you know who was in the 13 and who  
 17 was in the 9?  
 18 MS. PREDHAM:  
 19 A. It was based on the recommendations and which  
 20 category that they were in.  
 21 CHAYTOR, Q.C.:  
 22 Q. So who needed to get the treatment versus  
 23 those who already had treatment?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 36

1 CHAYTOR, Q.C.:  
 2 Q. And the one patient who was deceased, our  
 3 review indicates that she was panelled on  
 4 October 20th, 2005, and again on November  
 5 17th, 2005, and the first meeting notes, she  
 6 was deceased and not to be retested, and then  
 7 the second meeting gave the Mount Sinai  
 8 results. So it appears someone had requested  
 9 her specimen to be retested, although she was  
 10 known to be deceased. So in going through and  
 11 coming up with the list of 22, though, and the  
 12 fact that she was deceased, that didn't come  
 13 to your attention?  
 14 MS. PREDHAM:  
 15 A. I don't recall that one of them was deceased.  
 16 CHAYTOR, Q.C.:  
 17 Q. Do you recall any other discussion around the  
 18 table about deceased patients and whether or  
 19 not they would fit into the category of those  
 20 most impacted?  
 21 MS. PREDHAM:  
 22 A. As far as I was aware, we did not knowingly  
 23 talk about any deceased patients.  
 24 CHAYTOR, Q.C.:  
 25 Q. And again in terms of the--I believe you

Page 37

1 mentioned this yesterday, the 22 was not  
 2 intended to be exclusive?  
 3 MS. PREDHAM:  
 4 A. No.  
 5 CHAYTOR, Q.C.:  
 6 Q. That you're not surprised that there would be  
 7 others with metastatic disease or recurrences  
 8 that were not captured in your 22?  
 9 MS. PREDHAM:  
 10 A. Oh, absolutely not.  
 11 CHAYTOR, Q.C.:  
 12 Q. Up until the time of August '06 when you gave  
 13 that number?  
 14 MS. PREDHAM:  
 15 A. No.  
 16 CHAYTOR, Q.C.:  
 17 Q. And if we could have, please, P-0125, page 31.  
 18 This, Ms. Predham, we understand is the final  
 19 version which ends up copied to the premier,  
 20 members of his staff, Mr. Thompson, Mr. Cake,  
 21 whose name we're referred to earlier, and I'll  
 22 just take you to the end here first. It's  
 23 indicated to be prepared by/approved by  
 24 Heather Predham, Eastern Health; Moira  
 25 Hennessey, from the department, reviewed by

Page 38

1 Marilyn McCormack; Gary Cake, Cabinet  
 2 Secretariat. Do you agree that you prepared  
 3 this note?  
 4 MS. PREDHAM:  
 5 A. No, I didn't prepare that note. I prepared  
 6 "a" note that was going to Ms. Hennessey, but  
 7 I did not prepare that note.  
 8 CHAYTOR, Q.C.:  
 9 Q. Okay, and did you ever see this final version  
 10 of the note?  
 11 MS. PREDHAM:  
 12 A. Never.  
 13 CHAYTOR, Q.C.:  
 14 Q. I take it, until this process came -  
 15 MS. PREDHAM:  
 16 A. Yes, until this process.  
 17 CHAYTOR, Q.C.:  
 18 Q. Okay. Just take you through then and ask you  
 19 what portions that you did provide the  
 20 information for, and by the way, before you  
 21 signed off on providing the number 22 to  
 22 Marilyn McCormack, and I realize that you only  
 23 have vague recollections around the whole  
 24 thing, but would you have gone back and also  
 25 consulted with Ms. Pilgrim and Ms. Elliott

Page 39

1 prior to releasing that information?  
 2 MS. PREDHAM:  
 3 A. Well, not prior. If--you know, I think the  
 4 way it happened is that Ms. Pilgrim put her in  
 5 touch with me and I definitely had a  
 6 conversation with Ms. Pilgrim about what she  
 7 wanted, or information that she had after  
 8 that, and that was when it was discovered that  
 9 apparently somebody was upset that we were  
 10 talking directly to her, and--but that was,  
 11 that was all.  
 12 CHAYTOR, Q.C.:  
 13 Q. So when did that come up that someone was  
 14 upset that you were talking directly to her?  
 15 MS. PREDHAM:  
 16 A. It was after--it wasn't very long after, but  
 17 it--and again, you know, and that's probably  
 18 why the conversation sticks in my mind, the  
 19 limited amount it does, was that someone had  
 20 said that we shouldn't--somebody in the  
 21 Department of Health was upset because we were  
 22 talking directly there and the line of  
 23 communication was through the Department of  
 24 Health.  
 25 CHAYTOR, Q.C.:

Page 40

1 Q. And that got communicated to you by Ms.  
 2 Pilgrim?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And so you would have felt comfortable going  
 7 back to Ms. McCormack and providing her  
 8 information regarding the panel, regarding the  
 9 22, whatever her questions were to you at the  
 10 time?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. You would have provided that information and  
 15 not felt that you needed to go back to Ms.  
 16 Pilgrim or Ms. Elliott for sign off on that?  
 17 MS. PREDHAM:  
 18 A. No.  
 19 CHAYTOR, Q.C.:  
 20 Q. You would have felt comfortable just giving  
 21 that yourself, that information?  
 22 MS. PREDHAM:  
 23 A. Yes, Ms. Pilgrim asked me to do that. She  
 24 would know the type of things that I would say  
 25 because that was the information that I had.

Page 41

1 CHAYTOR, Q.C.:

2 Q. Perhaps we'll just go through and you can tell

3 us then what amongst this would have been the

4 information that you would have provided, and

5 the background refers to May, 2005, the lab

6 discovered some inconsistent results, and

7 refers to specifically ER and PR. Would that

8 be the type of information in trying to give

9 the background to Ms. McCormack?

10 MS. PREDHAM:

11 A. Could have been.

12 CHAYTOR, Q.C.:

13 Q. And the result, the receptor test direct the

14 treatment to be provided. So that's the

15 discussion around Tamoxifen?

16 MS. PREDHAM:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. Okay. "Since the discovery of these

20 inconsistent results, Eastern Health has

21 sent", and we've seen that you provided the

22 939 number, that's correct?

23 MS. PREDHAM:

24 A. Yes.

25 CHAYTOR, Q.C.:

Page 42

1 Q. Okay, "test results have been received on

2 923".

3 MS. PREDHAM:

4 A. I believe that's the numbers from the briefing

5 note.

6 CHAYTOR, Q.C.:

7 Q. Yes. "Eastern Health established a panel of

8 professionals, including medical, oncology,

9 pathology, surgery, and quality services, who

10 reviewed the test results". So that might

11 have come out of your conversation with Ms.

12 McCormack?

13 MS. PREDHAM:

14 A. Yes.

15 CHAYTOR, Q.C.:

16 Q. And the current status then, the pathology

17 reports, the total number of patients, 923

18 returned. "The following table details the

19 results from Mount Sinai and also provides

20 information on the 422 test results with

21 changes that were reviewed by the Newfoundland

22 and Labrador panel upon receipt", and then

23 again most of this information appears to be

24 what you had in your original, and I take it

25 you've had a chance since to look over this

Page 43

1 note and is there anything else that--the only

2 thing I could note at the time was the 176.

3 You had also provided the number 101.

4 MS. PREDHAM:

5 A. Yes.

6 CHAYTOR, Q.C.:

7 Q. Having been retested. Other than that, did

8 this appear to be basically the information

9 that you provided?

10 MS. PREDHAM:

11 A. There was nothing that struck me as being

12 dramatically different.

13 CHAYTOR, Q.C.:

14 Q. Okay, and then the issue of the two legal

15 claims, you don't recall having any discussion

16 around that?

17 MS. PREDHAM:

18 A. I think that was in the briefing note.

19 CHAYTOR, Q.C.:

20 Q. Right, yes, it was, thank you. "Recent media

21 reports identified Myrtle Lewis has joined

22 other women who have signed on to take part in

23 a class action", and the reference here to Ms.

24 Myrtle Lewis. Statement of Claim filed by Mr.

25 Ches Crosbie was served to the Defendant,

Page 44

1 Eastern Health, on July 7th, 2006. Would you

2 likely be the source of that type of

3 information?

4 MS. PREDHAM:

5 A. I may have been. Now my memory of my

6 conversation with her was I was over at the

7 Health Sciences and I was in someone else's

8 office when I talked to her, so I most likely

9 didn't have the date on hand when the

10 Statement of Claim was served, but the type of

11 issue there -

12 CHAYTOR, Q.C.:

13 Q. Yes, and the date that it was served, though,

14 on Eastern Health, I take it, would have to

15 come from within Eastern Health to be able to

16 provide that date?

17 MS. PREDHAM:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. And you're not aware of anyone else from

21 Eastern Health having discussion about this

22 briefing note with anyone from the government

23 other than yourself?

24 MS. PREDHAM:

25 A. No.

Page 45

1 CHAYTOR, Q.C.:

2 Q. And then summary, "The legal action

3 initiated", again that reference to it being a

4 different--a misdiagnosis, and that's probably

5 something you would have said along those

6 lines. "Eastern Health then advised 22 women

7 were impacted by the change in status of the

8 ER/PR receptor test. These women had changes

9 in the progress of their disease from the

10 initial confirmation and the beginning of

11 their treatment to the retesting done at Mount

12 Sinai".

13 MS. PREDHAM:

14 A. And that's certainly not what I would have

15 said there.

16 CHAYTOR, Q.C.:

17 Q. Okay, and it's been the subject of some

18 discussion here, the fact that the word

19 "greatly" is taken out. So when you were

20 providing the number 22, you were providing

21 that to indicate how many people were most

22 impacted?

23 MS. PREDHAM:

24 A. Yes. I--you know, what I've always said is

25 that they were all impacted, and that, you

Page 46

1 know, as I said right from the beginning,

2 those 22 were only to give some sense that you

3 couldn't just categorize these groups as, you

4 know, better or worse. You know, like, it

5 was--there was nuances in each of the groups,

6 and I would have had that discussion with her.

7 I certainly wouldn't have put it--I wouldn't

8 have written that paragraph.

9 CHAYTOR, Q.C.:

10 Q. And had this come back to you for review,

11 would you have taken exception to that

12 paragraph?

13 MS. PREDHAM:

14 A. Oh, yes, because it's incorrect.

15 CHAYTOR, Q.C.:

16 Q. And, "However, all of the 939 patients, or

17 families of those who have died whose tests

18 results were reviewed, could potentially

19 become applicants in a class action lawsuit",

20 and this in reading it would indicate that 939

21 patients or families of those who have died

22 would leave the inference perhaps that, well,

23 all of the deceased patients, all 176 have

24 been retested and reviewed. 939 were not

25 reviewed?

Page 47

1 MS. PREDHAM:

2 A. No, no, they weren't, none of the deceased

3 were reviewed.

4 CHAYTOR, Q.C.:

5 Q. "could potentially become applicants in the

6 class action. The basis of their claims may

7 differ depending on the criteria the lawyer

8 initiating has included in his claim for

9 damages, not only the problem with the lab

10 where test results were inaccurate, but also

11 the stress suffered by those who were told in

12 advance that the testing was being repeated,

13 and the time they were required to wait before

14 information was available to them. Currently

15 legal counsel for Eastern Health is reviewing

16 the legal position for Eastern Health". So in

17 terms of that, would you have provided that

18 information or that type of information?

19 MS. PREDHAM:

20 A. That's not exactly what I said in the briefing

21 note.

22 CHAYTOR, Q.C.:

23 Q. It's a little bit different, and is there any

24 part of it that you would take exception to?

25 MS. PREDHAM:

Page 48

1 A. Well, it seemed like a done deal there. Mine

2 was more, you know, potential for anything

3 else, like, it was--you know, we did have two

4 claims, but we could have had others.

5 CHAYTOR, Q.C.:

6 Q. And then the impacts of treatment with

7 Tamoxifen, and we've had some discussion about

8 that.

9 MS. PREDHAM:

10 A. I couldn't have given her that information.

11 CHAYTOR, Q.C.:

12 Q. You could not have?

13 MS. PREDHAM:

14 A. No. I would know that it wasn't a benign

15 drug, there were impacts of taking it, and I

16 did know that if you had a DVT, which was a

17 blood clot in the leg, that you could have--

18 you wouldn't be able to take it, and I did

19 know that there was potential for endometrial

20 cancer, but I wouldn't be able to go through

21 the abnormal growth, the hair and nail

22 thinning, fertility problems. I have no

23 knowledge of that.

24 CHAYTOR, Q.C.:

25 Q. "And the patients, however, who did not

Page 49

1 receive Tamoxifen, but are ER/PR positive, may  
 2 experience further problems with cancer". How  
 3 about a statement to that effect?  
 4 MS. PREDHAM:  
 5 A. I have no knowledge of that.  
 6 CHAYTOR, Q.C.:  
 7 Q. And then we have, "Reasons for the erroneous  
 8 results and steps taken to prevent  
 9 reoccurrence. Eastern Health engaged external  
 10 consultants to review the procedures at the  
 11 laboratory. When all reports are received,  
 12 they will be reviewed and the recommendations  
 13 will be implemented. The goal is to have the  
 14 laboratory accredited. Until these processes  
 15 are completed, all samples will continue to be  
 16 retested at Mount Sinai". Did you provide  
 17 that information to Ms. McCormack?  
 18 MS. PREDHAM:  
 19 A. I don't think so because I wouldn't have said  
 20 that.  
 21 CHAYTOR, Q.C.:  
 22 Q. What would you have said?  
 23 MS. PREDHAM:  
 24 A. Well, the reviews had been done and the--it  
 25 sounds like it's in the future, when actually

Page 50

1 it was ongoing at that time.  
 2 CHAYTOR, Q.C.:  
 3 Q. So if you had a discussion with Ms. McCormack,  
 4 would you have told her that, that the reviews  
 5 are done, we have the reports, we're working  
 6 on the recommendations?  
 7 MS. PREDHAM:  
 8 A. Yes, and I would have to direct her to Mr.  
 9 Gulliver or Dr. Denic to get a further update  
 10 on that, if I had that discussion with her.  
 11 CHAYTOR, Q.C.:  
 12 Q. But you have no recollection of any  
 13 discussion. So if Ms. McCormack says  
 14 otherwise, and that this, in fact, is the  
 15 impression that she was left with from your  
 16 discussion, and she does have a clear  
 17 recollection, can you take issue with that?  
 18 MS. PREDHAM:  
 19 A. I would have to because that wasn't the  
 20 information that--I mean, I knew the results  
 21 were back, I knew that Mr. Gulliver and Dr.  
 22 Cook originally, and then Dr. Denic, were  
 23 developing the recommendations, and were in  
 24 the process of implementing them. I didn't  
 25 know what they were doing and I didn't know

Page 51

1 any of the details of that, but I wouldn't  
 2 have said that because I knew different.  
 3 CHAYTOR, Q.C.:  
 4 Q. And if we could just look at what Ms.  
 5 McCormack said, please. It's the transcript  
 6 of June 12th, 2008, at page 287. On the  
 7 bottom here, you'll see I'm directing her to  
 8 the same portion and the reasons for erroneous  
 9 results. She says, "I probably drafted that  
 10 having a discussion with Moira and Heather  
 11 Predham". "Okay, and are you able to say that  
 12 you discussed this with Ms. Hennessey". "Yes,  
 13 I'm sure that we did. The note went back and  
 14 forth and that was my understanding of what  
 15 was happening from Health's perspective".  
 16 "Okay, and you also recall discussing it with  
 17 Ms. Predham". "Yes". "What did you  
 18 understand was the stage of the external  
 19 consultant's review". "That it was ongoing  
 20 and that there was no concern at that time  
 21 regarding current patients because the samples  
 22 were being tested, retested or tested outside  
 23 the province". "Who told you that the review  
 24 was ongoing". "Heather". "And did she  
 25 indicate to you that the reviewers had been

Page 52

1 back in the spring". "No, I understood the  
 2 review was ongoing as we talked". "Did you  
 3 understand that it was true of all of it, or  
 4 was there just some piece of it that they were  
 5 waiting on. What exactly did she tell you".  
 6 "I understood the review was ongoing, that  
 7 they were waiting for a report, which would  
 8 provide them with recommendations to accredit  
 9 the lab, and that they intended to implement  
 10 the recommendations, and at the current time  
 11 there was no concern about the present testing  
 12 because it was being done out of the  
 13 province". "Did she tell you there was one  
 14 report that they were waiting on, or did she  
 15 tell you they had already received certain  
 16 reports". "I wasn't told that there was any  
 17 reports ever received. My understanding was  
 18 the actual review and the consultants were  
 19 currently involved in reviewing the procedures  
 20 at the laboratory". "So were you told that  
 21 they had actually already been in twice, and  
 22 had gone, and that there were reports within  
 23 Eastern Health". "No, I was not". "Based on  
 24 your discussion with Ms. Predham, does that  
 25 surprise you that is the case". "I've since

Page 53

1 heard that they had actually received some  
 2 reports, but I was not told that". "Okay, and  
 3 based on your discussion that you had with  
 4 her, does that surprise you". "Yes, I would  
 5 have thought if they had reports that she  
 6 would have said the consultants had finished  
 7 their work or finished part of their work and  
 8 that they had, you know, and shared the  
 9 findings, but I did not know that, and  
 10 obviously I don't know if Moira knew it, but  
 11 she reviewed the note and I would assume if  
 12 she looked at it and said--and was aware that  
 13 there had been external consultants reports  
 14 received, internal or otherwise, that she  
 15 would have corrected that information because  
 16 she would have known that the information was  
 17 going forward to the premier's office. I will  
 18 be very disappointed if I had thought she'd  
 19 known, and I don't know if she did know it,  
 20 but if she did know it, and had not shared  
 21 that with me--because that would be sending  
 22 forward incorrect information". "Do you  
 23 specifically remember discussing that portion  
 24 of the note with Ms. Hennessey". "I don't  
 25 specifically recall discussing that particular

Page 54

1 part of the note, but as I said, I mean, when  
 2 the note was in its final stage, it went to  
 3 Moira for approval". "So what you're saying  
 4 is that you drafted this portion of the note  
 5 based on information given to you by Ms.  
 6 Predham". "Yes". "That it was sent back to  
 7 Ms. Hennessey for review". "Yes, and there  
 8 was no discussion back from Ms. Hennessey as  
 9 to any inaccuracy in that portion of the  
 10 note". So, Ms. Predham, it appears that Ms.  
 11 McCormack has clearly said that she received  
 12 the information from you. Are you able to  
 13 respond or refute that?  
 14 MS. PREDHAM:  
 15 A. Well my only response since I can't remember  
 16 the conversation with her, is that I wouldn't  
 17 have said that and if it was so important to  
 18 make sure that the information was accurate  
 19 that was going to the Premier, you would think  
 20 that based on a verbal conversation she would  
 21 send me the draft of that briefing note to  
 22 confirm that she had got it correct. And  
 23 that's all I can say about that.  
 24 CHAYTOR, Q.C.:  
 25 Q. Is there anything else at all that you can

Page 55

1 recall about--if we could just go back,  
 2 please, to P-0125? And then, of course, the  
 3 action I've already asked you about that and  
 4 you would not have indicated that your legal  
 5 counsel or officials from Eastern Health would  
 6 be available. Is there anything else at all  
 7 that you recall about this briefing note and  
 8 how it became developed?  
 9 MS. PREDHAM:  
 10 A. That's it. I have no memory of the one with  
 11 Ms. Hennessey, I had this vague recollection  
 12 of a telephone call with Ms. McCormack and I  
 13 have no other information.  
 14 CHAYTOR, Q.C.:  
 15 Q. And if we could have, please -  
 16 THE COMMISSIONER:  
 17 Q. Ms. Predham, regarding the deceased, I just  
 18 want to make sure I understand exactly what  
 19 happened in respect of the retest results from  
 20 the deceased.  
 21 MS. PREDHAM:  
 22 A. Okay.  
 23 THE COMMISSIONER:  
 24 Q. I understand you said this morning that  
 25 accepted in respect of those persons who you

Page 56

1 did not know were deceased at that time, your  
 2 view was that non of the deceased were  
 3 panelled, is that correct?  
 4 MS. PREDHAM:  
 5 A. Exactly, yes.  
 6 THE COMMISSIONER:  
 7 Q. And has anything--did anything change in  
 8 respect of that when the plan was developed to  
 9 give results to families if they requested it?  
 10 MS. PREDHAM:  
 11 A. Originally as it worked out, if a family  
 12 member requested the results and they were  
 13 confirmed negative, then we would tell them  
 14 that information. If they had changed, we'd  
 15 put them in touch with, they would meet with  
 16 the oncologists or Dr. Laing. As it  
 17 progressed, when we did the retesting and made  
 18 the announcement in 2007, we had a lot of  
 19 discussion on how we would deal with the  
 20 results that had changed.  
 21 THE COMMISSIONER:  
 22 Q. Uh-hm.  
 23 MS. PREDHAM:  
 24 A. And we'd come up with various potential ways,  
 25 the oncologists didn't feel comfortable

Page 57

1 dealing with the people who were not their  
 2 patients.  
 3 THE COMMISSIONER:  
 4 Q. Uh-hm.  
 5 MS. PREDHAM:  
 6 A. And then there was the intent to get a  
 7 consultant oncologist who could talk to  
 8 families. So it went--it progressed in that  
 9 note.  
 10 THE COMMISSIONER:  
 11 Q. Yeah, but so what you're saying is that in  
 12 addition to those persons who might have, as  
 13 it were, an error had been reviewed by the  
 14 panel because their results had changed -  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 THE COMMISSIONER:  
 18 Q. Some of the families of deceased members would  
 19 have heard from you in those early days  
 20 because they received the information about  
 21 the confirmed negative.  
 22 MS. PREDHAM:  
 23 A. Or they called in later on.  
 24 THE COMMISSIONER:  
 25 Q. Okay, and then you reached a point where the

Page 58

1 new plan was put into action regarding  
 2 deceased patients where the families  
 3 themselves had to make the contact?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 THE COMMISSIONER:  
 7 Q. So you would have had a number of results,  
 8 some of which would have been communicated,  
 9 some of which would have not.  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 THE COMMISSIONER:  
 13 Q. Because we do know that the number of deceased  
 14 patients were in fact in the early days  
 15 tested.  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 THE COMMISSIONER:  
 19 Q. And further on up, so you would have had that  
 20 kind of--for a period of time you were in that  
 21 category.  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 THE COMMISSIONER:  
 25 Q. Some tested, some not tested, some informed,

Page 59

1 some not informed.  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 THE COMMISSIONER:  
 5 Q. Then you came up with a larger plan, as it  
 6 were, the results of which would not--the  
 7 results in respect of the deceased patients  
 8 whose families had not already heard, would  
 9 not be conveyed unless they made contact, is  
 10 that correct?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 THE COMMISSIONER:  
 14 Q. And if that family made contact and it was a  
 15 case where the results had changed, how did  
 16 you deal with that?  
 17 MS. PREDHAM:  
 18 A. Up to a certain point, we got an oncologist or  
 19 Dr. Laing would meet with the family and go  
 20 over those results.  
 21 THE COMMISSIONER:  
 22 Q. Yes.  
 23 MS. PREDHAM:  
 24 A. After a certain point and I'm not sure of the  
 25 reasoning, they decided that they wouldn't do

Page 60

1 that any more unless it was their own patients  
 2 and then, so then we were investigating--  
 3 trying to obtain an oncologist to do that and  
 4 we couldn't do that, so then the director of  
 5 the Cancer Care Program was the contact for  
 6 those patients and it would go through that -  
 7 THE COMMISSIONER:  
 8 Q. Ms. Smith.  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 THE COMMISSIONER:  
 12 Q. So really in respect of deceased patients,  
 13 what occurred depended on the stage you were  
 14 in along the way?  
 15 MS. PREDHAM:  
 16 A. Yes, that's a good way of putting it.  
 17 THE COMMISSIONER:  
 18 Q. And very few of them would have gone through  
 19 the panelling process.  
 20 MS. PREDHAM:  
 21 A. Yes, very few.  
 22 THE COMMISSIONER:  
 23 Q. And do you know whether or not there is a plan  
 24 in fact to do that for them? Harkening back  
 25 to your own concern which you expressed here

Page 61

1 about what one validly conclude from the data,  
 2 absent those particular records having been  
 3 examined in the same way that the earlier ones  
 4 were.  
 5 MS. PREDHAM:  
 6 A. Well see, that's--yes, because you can't--  
 7 that's the problem with only having the panel  
 8 results and doing any conclusions based on  
 9 those--these numbers, the 939 and all that  
 10 because it's not a true analysis of that. And  
 11 really what the plan of any more information  
 12 with the deceased, I'm not aware of, I don't  
 13 know what's going on.  
 14 THE COMMISSIONER:  
 15 Q. All right, thank you. Sorry, Ms. Chaytor.  
 16 CHAYTOR, Q.C.:  
 17 Q. Thank you, that's fine. If we could have,  
 18 please, P-1179? And this is an e-mail  
 19 exchange, Ms. Predham, in which you write to  
 20 Ms. Elliott, "Please read below, I have no  
 21 idea how we could have missed this lady so  
 22 completely." And this is October 4th now,  
 23 2006. "Unless she was a consult on request by  
 24 the physician, but if so, the physician should  
 25 have told her. I'll keep you updated.

Page 62

1 Meanwhile, we have another lady who has died  
 2 but converted. Her husband is in Corner  
 3 Brook." And there's discussion about her.  
 4 And you will see here the details on it is "A  
 5 lady called Nancy on Monday asking if she had  
 6 been retested. Apparently she had called in  
 7 the fall asking if there was retesting and  
 8 would she be involved. She was told yes and  
 9 that someone would be in touch. She called in  
 10 on Monday asking if there's been any word on  
 11 her retesting as she hadn't heard anything.  
 12 She was diagnosed with cancer in 1999, May,  
 13 1999, showed faint positivity in less than 20  
 14 percent and there's an addendum on her  
 15 pathology report, November 4th, 2005, with the  
 16 results: ER, 90; PR 40. I've gone through  
 17 every scrap of paper related to ER/PR that I  
 18 have and I cannot find her name anywhere. We  
 19 certainly didn't panel her. Can we quickly  
 20 review her via phone or something and then get  
 21 the letter to her GP." Now, Ms. Predham,  
 22 obviously this is someone who you would have  
 23 had her name at some point because she was in  
 24 fact, called in the fall or she had called in  
 25 the fall and had advised that she was being

Page 63

1 retested. So I would assume there would have  
 2 been a record of her telephone call at that  
 3 point in time and she would have been--  
 4 wouldn't she not have been put on a list then  
 5 at that time to make sure she was included?  
 6 MS. PREDHAM:  
 7 A. If I'm thinking of the same situation, I think  
 8 when we looked back, she had called probably  
 9 the day after the media results came out or it  
 10 might have been--she called at a very early  
 11 time and it was more of a general discussion,  
 12 if I had breast cancer and, you know, if this  
 13 had happened to me, would I be retested, more  
 14 of a generic type of conversation. We should  
 15 have picked up her name in that, but it wasn't  
 16 because it wasn't identified that she was an  
 17 actual person at that time.  
 18 CHAYTOR, Q.C.:  
 19 Q. Well she was told yes, she was going to be  
 20 retested and that someone would be in touch  
 21 with her.  
 22 MS. PREDHAM:  
 23 A. If I'm thinking of the same one, it was when  
 24 we went back and looked, it was more of a  
 25 generic type of a conversation that was held,

Page 64

1 but we didn't pick up her name at that time.  
 2 CHAYTOR, Q.C.:  
 3 Q. So when you went back and looked, you mean on  
 4 October 4th, 2006?  
 5 MS. PREDHAM:  
 6 A. Yes, if I'm thinking of the right case.  
 7 CHAYTOR, Q.C.:  
 8 Q. So you're able to confirm and then pass on to  
 9 Dr. Laing and Dr. Denic and others that she  
 10 had been told she would be retested and  
 11 someone would be back to her.  
 12 MS. PREDHAM:  
 13 A. Yes, that's what I have here. But as I  
 14 recall, it was more generic, we didn't  
 15 identify, oh yes, this lady has to be retested  
 16 and we told her yes, you will be retested. It  
 17 wasn't that type of a conversation, it was  
 18 more of a generic one that, you know, as this  
 19 progresses. I can't remember the details  
 20 right now, but it was more generic than, in  
 21 fact yes, we're taking down your name.  
 22 CHAYTOR, Q.C.:  
 23 Q. And it was important for people and you  
 24 understood at the time with your concerns  
 25 about your list, it was important for people



Page 65

1 to self identify.  
 2 MS. PREDHAM:  
 3 A. Oh definitely and she was--you know,  
 4 unfortunately she was missed on that route.  
 5 CHAYTOR, Q.C.:  
 6 Q. So she had called, self identified, fell  
 7 through the cracks somehow and didn't get  
 8 retested.  
 9 MS. PREDHAM:  
 10 A. Oh she did get retested.  
 11 CHAYTOR, Q.C.:  
 12 Q. Got retested, sorry, didn't get panelled, her  
 13 retest was done back and put on her--her  
 14 result was actually put on her chart in  
 15 November, November 4th, 2005, the addendum is  
 16 actually added to her chart.  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CHAYTOR, Q.C.:  
 20 Q. And that happened without her or her physician  
 21 apparently ever becoming aware?  
 22 MS. PREDHAM:  
 23 A. No, I believe she was a consult, that the  
 24 physician had ordered the retest and I believe  
 25 that the results came back and I'm not sure

Page 66

1 what happened after that, but -  
 2 CHAYTOR, Q.C.:  
 3 Q. And who ordered her retest?  
 4 MS. PREDHAM:  
 5 A. Unless I went back and looked, I wouldn't be  
 6 able to tell you.  
 7 CHAYTOR, Q.C.:  
 8 Q. So the physician who ordered the retest also  
 9 missed her in following up with her to let her  
 10 know?  
 11 MS. PREDHAM:  
 12 A. Like I said, I'd have to go back and look, go  
 13 back through that story again.  
 14 CHAYTOR, Q.C.:  
 15 Q. But what do you--so you don't now know what  
 16 happened with this particular patient?  
 17 MS. PREDHAM:  
 18 A. I can't remember right now.  
 19 CHAYTOR, Q.C.:  
 20 Q. But it appears if what you've written here  
 21 back on October 4th, 2005 is correct, is that  
 22 you had no record of her anywhere.  
 23 MS. PREDHAM:  
 24 A. No.  
 25 CHAYTOR, Q.C.:

Page 67

1 Q. She had not been told her results and for some  
 2 reason, the pathology addendum got entered on  
 3 her chart without ever her particular  
 4 situation coming to the panel?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 THE COMMISSIONER:  
 8 Q. She should have, would you agree, she should  
 9 have been on your list for retesting, having  
 10 met the criteria in any event.  
 11 MS. PREDHAM:  
 12 A. Oh yes.  
 13 THE COMMISSIONER:  
 14 Q. And did you ever have any process for figuring  
 15 out why these people who fell through the  
 16 cracks had actually done so, in the sense of  
 17 why did we miss this person?  
 18 MS. PREDHAM:  
 19 A. We did work through that and I can't recall  
 20 for her, there was a lot of different factors  
 21 that, you know, that contributed to that, but  
 22 I can't remember specifically for her.  
 23 CHAYTOR, Q.C.:  
 24 Q. And if we can look, please, at P-3044? And  
 25 this is a few days before that, September

Page 68

1 29th, 2006 and there's an inquiry from a  
 2 husband, you're writing to Ms. Elliott and  
 3 others that "I've had contact with this  
 4 gentleman. His wife's ER/PR had not been  
 5 retested. She was originally ER negative, PR  
 6 zero and the lab sent it to Mount Sinai when I  
 7 requested on September 15th. The results came  
 8 back on the 27th, she did not convert, the  
 9 results remain the same. I had called three  
 10 times in the interim and left messages at his  
 11 house. He did not respond. He called me  
 12 today in response to this e-mail and I was  
 13 able to give him the results." And this is  
 14 the e-mail, I take it, here?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. And apparently he had made contact with Ms.  
 19 Bonnell, is that correct?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And if we could have, please, P-3047? And  
 24 this appears to be a draft of a panel letter  
 25 and you will see that the person was panelled

Page 69

1 March 4th, 2006 and the recommendation of the  
 2 panel was that she should be offered treatment  
 3 with Tamoxifen and there's a handwritten note  
 4 here, "Heather, FYI, this lady never did get  
 5 contacted. Dr. Laing's office told me to  
 6 leave it with you." And it's October 6th,  
 7 2006, received by courier from Dr. Laing's  
 8 office and it appears while she had been  
 9 panelled March 4th, 2006, it's not October  
 10 12th, '06 and she still hasn't been told the  
 11 results. What do you recall about this  
 12 situation?  
 13 MS. PREDHAM:  
 14 A. We couldn't find her. She had moved and, you  
 15 know, it's hard without the names there, she  
 16 had moved and was being followed up in Ontario  
 17 and she has no--she was no longer being seen  
 18 by that group, they had no forwarding address  
 19 for her, no forwarding doctor and her GP that  
 20 was listed on that chart as well, had retired  
 21 and we had lost track of her, we couldn't  
 22 discover where she went after.  
 23 CHAYTOR, Q.C.:  
 24 Q. And do you know whether or not today she's  
 25 been contacted?

Page 70

1 MS. PREDHAM:  
 2 A. Yes, she has been contacted.  
 3 CHAYTOR, Q.C.:  
 4 Q. And when--around when was she contacted then?  
 5 MS. PREDHAM:  
 6 A. She was only contacted this summer.  
 7 CHAYTOR, Q.C.:  
 8 Q. And if we could look, please, at P-3048? And  
 9 this is an e-mail, you write October 18th, '06  
 10 to Leona Barrington and you write, "How's  
 11 this, Eastern Health is winding up its review  
 12 of estrogen and progesterone retesting. As  
 13 many people as possible have been contacted  
 14 and the results are currently being collated  
 15 for analysis. Eastern Health anticipates that  
 16 this review process will be completed by the  
 17 end of November, is that enough." And do you  
 18 recall, what were you providing this  
 19 information for?  
 20 MS. PREDHAM:  
 21 A. If I recall correctly, I think Ms. Barrington  
 22 was being contacted by the media and she had  
 23 either--she may have sent something to me or  
 24 something which said that we, you know, a  
 25 little summary of where it is and this was my

Page 71

1 suggestions of wording.  
 2 CHAYTOR, Q.C.:  
 3 Q. And I note here, Ms. Predham, that you are  
 4 saying "as many people as possible have been  
 5 contacted".  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. So that's a qualified statement.  
 10 MS. PREDHAM:  
 11 A. Oh yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. Did you ever assert definitively that all  
 14 patients had been contacted?  
 15 MS. PREDHAM:  
 16 A. Never.  
 17 CHAYTOR, Q.C.:  
 18 Q. Do you know if anyone in your department did?  
 19 MS. PREDHAM:  
 20 A. In our department?  
 21 CHAYTOR, Q.C.:  
 22 Q. Yes.  
 23 MS. PREDHAM:  
 24 A. Never.  
 25 CHAYTOR, Q.C.:

Page 72

1 Q. Ms. Elliott for example?  
 2 MS. PREDHAM:  
 3 A. I can't imagine.  
 4 CHAYTOR, Q.C.:  
 5 Q. Were you ever present when she made such a  
 6 statement?  
 7 MS. PREDHAM:  
 8 A. I can't recall.  
 9 CHAYTOR, Q.C.:  
 10 Q. And where would Ms. Elliott get her  
 11 information if she were to make such a  
 12 statement, where would she get her information  
 13 about patient contacts?  
 14 MS. PREDHAM:  
 15 A. Oh, from myself or Ms. Parsons.  
 16 CHAYTOR, Q.C.:  
 17 Q. Okay, and did you ever tell that to Ms.  
 18 Elliott, that all patients had been contacted?  
 19 MS. PREDHAM:  
 20 A. I never said all patients had been contacted.  
 21 I never said that every number was definitive,  
 22 I've never ever--I always qualified everything  
 23 that I said.  
 24 CHAYTOR, Q.C.:  
 25 Q. And did you ever have any direct discussions

Page 73

1 with Mr. Tilley on that or were you present  
 2 when it was discussed with Mr. Tilley as to  
 3 whether or not, do we now have everyone? Has  
 4 everyone been contacted?  
 5 MS. PREDHAM:  
 6 A. I can't recall any--I can't recall not, but I  
 7 can't recall any.  
 8 CHAYTOR, Q.C.:  
 9 Q. And if you had been -  
 10 THE COMMISSIONER:  
 11 Q. Sorry if I'm interrupting, there's so many  
 12 "nots" in that, that I'm not sure what  
 13 everybody is confirming or denying here.  
 14 MS. PREDHAM:  
 15 A. I'm not saying that I didn't say anything to  
 16 Mr. Tilley, but right now I can't think of any  
 17 -  
 18 THE COMMISSIONER:  
 19 Q. You didn't discuss the subject with Mr. Tilley  
 20 or -  
 21 MS. PREDHAM:  
 22 A. I may have discussed it with him, but right  
 23 now I can't think of any time that I did.  
 24 THE COMMISSIONER:  
 25 Q. Okay.

Page 74

1 CHAYTOR, Q.C.:  
 2 Q. And in any event, you would not have told him  
 3 everyone was contacted.  
 4 MS. PREDHAM:  
 5 A. I've never said that in my life.  
 6 CHAYTOR, Q.C.:  
 7 Q. Okay. And if we could have, please, P-1188?  
 8 And this e-mail exchange begins from yourself,  
 9 October 26th, 2006 and it goes to a number of  
 10 people, including Dr. Howell, Dr. Denic, Terry  
 11 Gulliver, Pam Elliott, Pat Pilgrim, Susan  
 12 Bonnell, Sharon Smith, Kara Laing and copied  
 13 to others. And you're writing about a person  
 14 who was diagnosed with breast cancer in 1999.  
 15 You give her original results. She had been  
 16 treated with Tamoxifen for a period and then  
 17 switched to Femara. "The panel had much  
 18 discussion and debate on how best to disclose  
 19 this information to the client. The original  
 20 intent was a meeting with the clinical chiefs  
 21 and someone from QRM, but a complicating  
 22 factor at the time was the media coverage  
 23 after the DCIS meetings. Upon further review,  
 24 the panel decided that we had earlier  
 25 discovered another retro converter who was

Page 75

1 contacted via the most responsible physician,  
 2 our usual process. Therefore, the day after  
 3 the panel meeting, September 8th, 2006, Kara,  
 4 on behalf of the panel, wrote to the most  
 5 responsible physician to recommend that she  
 6 remain off the Femara and not receive any  
 7 further hormonal therapy." I just want to  
 8 stop you there for a moment because why would  
 9 the panel have much discussion on debate of  
 10 how to best disclose the information to the  
 11 client or to the patient?  
 12 MS. PREDHAM:  
 13 A. As I recall, the discussion was around whether  
 14 you meet with this person or these people, or  
 15 whether we send a letter. With the-when we  
 16 discussed the people for the DCIS, the mis-  
 17 diagnosis patients, it was very clear that  
 18 they would have to meet with them and go  
 19 through this, but--and that was their first  
 20 choice, but then they were concerned that if  
 21 they contacted somebody and said come in, we  
 22 have to discuss something with you, the  
 23 clinical chief was--just because it was in the  
 24 media at that time, they might automatically  
 25 think that they were mis-diagnosed. And then

Page 76

1 when it was discovered that we had already  
 2 sent a letter about a retro converter, they  
 3 felt that this was the most appropriate route  
 4 to go.  
 5 CHAYTOR, Q.C.:  
 6 Q. Now in terms of how to, though, best disclose  
 7 the information to the client, we looked the  
 8 other day at, I think it's P-0057, the  
 9 disclosure policy for the organization. So it  
 10 would be, it's fairly straightforward, I would  
 11 suggest as to how, in such a situation, you  
 12 inform patients and so why would there have to  
 13 be a discussion and debate about, well we have  
 14 a policy in place, here's what we have to do?  
 15 MS. PREDHAM:  
 16 A. Well it's a guideline, not a policy, but also  
 17 I guess their discussion was about whether or  
 18 not this was--telling somebody that they did  
 19 not have the type of cancer that they had  
 20 and/or telling them the treatment  
 21 recommendation that your ER/PR results had  
 22 changed and now there's a treatment change,  
 23 you know, this was a conversation between the  
 24 clinical chiefs and the clinicians that were  
 25 there. My intent was that they had to be

Page 77

1 disclosed, how are you going to do it? So,  
 2 you know, to debate the two sides of it, you'd  
 3 really have to ask them.  
 4 CHAYTOR, Q.C.:  
 5 Q. And the media coverage, again, how was that a  
 6 complicating factor at the time?  
 7 MS. PREDHAM:  
 8 A. I do remember the comment made by one of the  
 9 oncologists, I'm not sure which one, but the  
 10 comment was made that, you know, if we call  
 11 somebody now to come in for a meeting with us,  
 12 would they automatically think that they were  
 13 mis-diagnosed.  
 14 CHAYTOR, Q.C.:  
 15 Q. And you point out that it's, well not a  
 16 policy, it's a guideline, but in any event,  
 17 why wouldn't that guideline be applicable in  
 18 this case?  
 19 MS. PREDHAM:  
 20 A. Well, we had just gone through all this time  
 21 of panelling of these changed results and we  
 22 had a letter go out, so as they went through  
 23 this discussion, they decided to keep it with  
 24 our regular route of sending out a letter.  
 25 CHAYTOR, Q.C.:

Page 78

1 Q. I take it unless there's strong indicators to  
 2 do otherwise, you follow your guideline?  
 3 MS. PREDHAM:  
 4 A. Well it's--the guideline is a suggested route  
 5 and that's what you'd typically would do in a  
 6 situation. Of course, those guidelines were  
 7 written for a situation involving one patient  
 8 with a final outcome and you know, but this  
 9 was part of a larger process.  
 10 CHAYTOR, Q.C.:  
 11 Q. But this is one patient with a final outcome.  
 12 Each of these patients are one patient with a  
 13 final outcome.  
 14 MS. PREDHAM:  
 15 A. Oh exactly, but not in the--there's a high  
 16 volume of them, but the plan that had been  
 17 decided the previous October was to go through  
 18 the results and recommended change in  
 19 treatment and what the clinicians sitting  
 20 around the table decided that the best route  
 21 was to follow the route that was planned and  
 22 write a letter to these people.  
 23 CHAYTOR, Q.C.:  
 24 Q. And you go on then to say, "Yesterday  
 25 afternoon, Nancy received a phone call from"--

Page 79

1 and I take it, it was from the patient?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. Apparently one of the doctors sent the letter  
 6 to the family physician and -  
 7 MS. PREDHAM:  
 8 A. Then the family physician gave her the letter.  
 9 CHAYTOR, Q.C.:  
 10 Q. Gave the letter to the patient and "The  
 11 patient called Nancy to get contact  
 12 information on the group that is suing Eastern  
 13 Health, which Nancy declined to give." What  
 14 do you recall about that?  
 15 MS. PREDHAM:  
 16 A. I don't recall anything about Nancy declining  
 17 to give that, all I remember, I was very upset  
 18 about this, and the way this progressed and,  
 19 you know, probably if I waited ten more  
 20 minutes, I wouldn't have said the certain  
 21 words that I said in this e-mail but I was  
 22 very mad at the time.  
 23 CHAYTOR, Q.C.:  
 24 Q. And why were you so upset? What was so  
 25 upsetting about this?

Page 80

1 MS. PREDHAM:  
 2 A. Well, you know, it was just hard, you know,  
 3 you wanted to do the right thing and there was  
 4 no need for this to happen to her.  
 5 CHAYTOR, Q.C.:  
 6 Q. And so what was it that had happened to the  
 7 patient that was so upsetting to you? She  
 8 received the letter and so she's informed by  
 9 her family physician.  
 10 MS. PREDHAM:  
 11 A. Well the first person we sent it to sent the  
 12 letter to her family physician who called her  
 13 in and said, "this letter is for you" and gave  
 14 it to her without context, without  
 15 information.  
 16 CHAYTOR, Q.C.:  
 17 Q. And was the letter--those letters were copied  
 18 to the family physicians, were they not?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. So in sending the letter then to her, wasn't  
 23 it--or sending--or copying them to the family  
 24 physicians, wasn't that a possibility of what  
 25 could happen that if they're in to see their

Page 81

1 family physician or the family physician makes  
 2 contact to make sure the person knows, isn't  
 3 that what very likely could have happened?  
 4 MS. PREDHAM:  
 5 A. Well the reason that we, you know, in quality  
 6 didn't disclose the information, you know, if  
 7 we were given the direction by the physicians  
 8 to say yes, you can call the people up and  
 9 tell them, or the fact that we didn't write a  
 10 letter to the patients was because they needed  
 11 the context of what that meant to them.  
 12 CHAYTOR, Q.C.:  
 13 Q. And you're saying the family physician  
 14 couldn't give that context?  
 15 MS. PREDHAM:  
 16 A. He didn't give that context, he just gave the  
 17 letter, he didn't give any explanation of what  
 18 it meant. He just gave the letter. Now this  
 19 is according to the lady who called us.  
 20 CHAYTOR, Q.C.:  
 21 Q. Yes. And sending out and deciding to go with  
 22 the letter as opposed to following the  
 23 guideline of having the patient in, sitting  
 24 down, speaking with her -  
 25 MS. PREDHAM:

Page 82

1 A. Well we followed the letter because it was  
 2 more like all the other letters that we had  
 3 sent.  
 4 CHAYTOR, Q.C.:  
 5 Q. So what did you think was going to happen by  
 6 sending the letter? What was supposed to have  
 7 happened?  
 8 MS. PREDHAM:  
 9 A. Well the first physician, the most responsible  
 10 physician should have called her in and sat  
 11 down and explained that her results had  
 12 changed and this is the impact on your  
 13 treatment, that's what I expected to happen.  
 14 CHAYTOR, Q.C.:  
 15 Q. And you don't have any recollection of Nancy  
 16 actually refusing to give the lady the  
 17 information about who is suing Eastern Health?  
 18 MS. PREDHAM:  
 19 A. No, I don't.  
 20 CHAYTOR, Q.C.:  
 21 Q. And why would you put that in your e-mail?  
 22 MS. PREDHAM:  
 23 A. I don't know, obviously I had some information  
 24 about that at the time, but I don't know why.  
 25 CHAYTOR, Q.C.:

Page 83

1 Q. "So I can only assume that Mr. Crosbie will  
 2 now have another story. I anticipate that he  
 3 will call for a total retest of all ER/PR  
 4 results. We did discuss that at the panel  
 5 letter, but there is documented false positive  
 6 rate with this test and five out of 962 falls  
 7 well within that range. Of course, we can  
 8 revisit this decision." Is your concern that  
 9 now the knowledge of this is out there, this  
 10 retro converter case and that in fact,  
 11 somebody such as Mr. Crosbie may come forward  
 12 and say, well what about your positives and  
 13 let's get them retested? That's your concern?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. And you're saying five out of 962 and what was  
 18 your knowledge of the total number of retro  
 19 converters as of October 26th, 2006?  
 20 MS. PREDHAM:  
 21 A. Was four out of 962.  
 22 CHAYTOR, Q.C.:  
 23 Q. Four that what, required treatment change?  
 24 MS. PREDHAM:  
 25 A. Required treatment change.

Page 84

1 CHAYTOR, Q.C.:  
 2 Q. And total number, however, of retro converters  
 3 was much higher than that.  
 4 MS. PREDHAM:  
 5 A. And it really wasn't until November of  
 6 December that I started to differentiate, it  
 7 was probably late November that I was  
 8 differentiating that the numbers that we had  
 9 from the panelling really didn't reflect the  
 10 issue that we had because of the, well as I  
 11 said before, because of the treatment side of  
 12 it. There was more influences on treatment  
 13 than just the ER/PR numbers. So it was after  
 14 this time that I started thinking, you know,  
 15 that's really not right. These are four that  
 16 had a treatment change based on the going back  
 17 down to zero, but that's not all the retro  
 18 converters.  
 19 CHAYTOR, Q.C.:  
 20 Q. And this number five out of 962 wouldn't be  
 21 any indication as to whether or not your test  
 22 is falling within any, as you seem to indicate  
 23 there might be an accepted false positive  
 24 rate.  
 25 MS. PREDHAM:

Page 85

1 A. There was a discussion at the panel level  
 2 about that and whether or not there was a  
 3 documented false positive rate, which I've  
 4 never seen and I didn't get any evidence about  
 5 that, but -  
 6 CHAYTOR, Q.C.:  
 7 Q. And you've never come across it in your  
 8 research?  
 9 MS. PREDHAM:  
 10 A. I didn't do a lot at the time, but I couldn't  
 11 find it easily. But there was a discussion at  
 12 the panel level about that and there was some  
 13 acceptance that that was acceptable.  
 14 CHAYTOR, Q.C.:  
 15 Q. But it wouldn't be, in any event, you wouldn't  
 16 be using five or four to calculate that.  
 17 MS. PREDHAM:  
 18 A. No.  
 19 CHAYTOR, Q.C.:  
 20 Q. That wouldn't be correct.  
 21 MS. PREDHAM:  
 22 A. No.  
 23 CHAYTOR, Q.C.:  
 24 Q. If you're looking to see whether or not you've  
 25 got a problem with your positives, you're not

Page 86

1 going to just look at the ones that required a  
 2 treatment change.  
 3 MS. PREDHAM:  
 4 A. Absolutely not.  
 5 CHAYTOR, Q.C.:  
 6 Q. You would have also been aware at this point  
 7 in time that negative controls were not being  
 8 used throughout the time period.  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And what did you understand is the importance  
 13 of a negative control?  
 14 MS. PREDHAM:  
 15 A. Well the negative control works against the  
 16 false positive.  
 17 THE COMMISSIONER:  
 18 Q. Ms. Predham, can we go back to the content  
 19 regarding the lady who was the subject of this  
 20 memo in the first place?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 THE COMMISSIONER:  
 24 Q. And the point about what was expected of  
 25 physicians who had been contacted by you,

Page 87

1 without going into who the particular  
 2 physician was who sent the letter on to the  
 3 family physician, what I'm really interested  
 4 in knowing is whether that person is somebody  
 5 who you would have known would have received  
 6 information about what you were doing and what  
 7 was expected of them.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 THE COMMISSIONER:  
 11 Q. So you were in a position where you had reason  
 12 to believe that when this letter came to that  
 13 most responsible person, that responsible  
 14 person--that person would understand what was  
 15 expected of them, in terms of dealing with  
 16 this?  
 17 MS. PREDHAM:  
 18 A. Exactly.  
 19 THE COMMISSIONER:  
 20 Q. So that's the source of your real frustration  
 21 with this, the process of falling down at that  
 22 level?  
 23 MS. PREDHAM:  
 24 A. There was no need for that person to send that  
 25 letter on.

Page 88

1 THE COMMISSIONER:  
 2 Q. To the family physician?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 THE COMMISSIONER:  
 6 Q. And what about family physicians, what was  
 7 your understanding of what they would have  
 8 known if that kind of information got to them?  
 9 MS. PREDHAM:  
 10 A. I understand that they were aware of our  
 11 process and were aware that they would be  
 12 getting these letters.  
 13 THE COMMISSIONER:  
 14 Q. Was that all?  
 15 MS. PREDHAM:  
 16 A. I think we wrote to the family physicians  
 17 about that and also I think every letter had,  
 18 if you required more information, I'm sure  
 19 that every letter had that on it, about  
 20 contacting Dr. Laing.  
 21 THE COMMISSIONER:  
 22 Q. Yes. No, it's just that as I've heard about  
 23 this process along the way, I have sometimes  
 24 wondered about the position of a family  
 25 physician who would have gotten a letter, a

Page 89

1 general letter about the subject and then  
 2 maybe has a number of patients and he would  
 3 have, or she would have gotten copies of  
 4 letters regarding their patients, and then I  
 5 would anticipate that it would not be unusual  
 6 to find those patients walking through the  
 7 door. My question was whether or not the  
 8 family physicians were really in a position to  
 9 answer the questions of their patients?  
 10 MS. PREDHAM:  
 11 A. And what I found in, you know, after the fact  
 12 of, especially after the class action lawsuit  
 13 letter went and there was some feedback, I had  
 14 a discussion with the family physicians then  
 15 and also when we were doing the verification  
 16 of contact, the majority of them were aware  
 17 and, you know, took the letter and, you know,  
 18 did what was in it. Took it as, okay, this is  
 19 the recommendation for treatment and this is  
 20 what we'll do, and didn't have a problem with  
 21 it. You know, they understood what that was  
 22 and they appreciated that additional  
 23 information, rather than just getting a copy  
 24 of the pathology report where they would have  
 25 to, I guess, consider that. That was the

Page 90

1 feedback that I got.  
 2 THE COMMISSIONER:  
 3 Q. So what you're saying is the majority of the  
 4 family physicians would have appreciated the  
 5 fact that there had been a panel?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 THE COMMISSIONER:  
 9 Q. But how many of those people would not have  
 10 been patients of the Cancer Clinic in any  
 11 event?  
 12 MS. PREDHAM:  
 13 A. I'm not sure.  
 14 THE COMMISSIONER:  
 15 Q. Were not most of them patients of the Cancer  
 16 Clinic?  
 17 MS. PREDHAM:  
 18 A. They were, but they could have been discharged  
 19 a couple of years before and now being  
 20 followed by their family doctor. You know, if  
 21 somebody had cancer in, say, '97 and they were  
 22 discharged and now their family doctor is  
 23 following them.  
 24 THE COMMISSIONER:  
 25 Q. Would you not expect that people who were

Page 91

1 patients of the Cancer Clinic would stay with  
 2 them for at least five years?  
 3 MS. PREDHAM:  
 4 A. I'm not sure what the criteria discharge is  
 5 from the Cancer Clinic.  
 6 THE COMMISSIONER:  
 7 Q. Thank you. Ms. Chaytor.  
 8 CHAYTOR, Q.C.:  
 9 Q. And Ms. Predham, you go on to write "This  
 10 entire ER/PR review has been very difficult  
 11 and drawn out, with constant hard and  
 12 difficult decisions being made. The only  
 13 thing making it bearable at all was that we  
 14 were doing what we had to do to make it right  
 15 for our patients. We were always doing the  
 16 "right thing". Personally this, combined with  
 17 the two situations involving Dr. Ganguly in  
 18 the past two weeks has left me totally and  
 19 absolutely disheartened." And first of all,  
 20 what were the two situations with Dr. Ganguly?  
 21 Did that have anything to do with ER/PR?  
 22 MS. PREDHAM:  
 23 A. I can only think of one and it did.  
 24 CHAYTOR, Q.C.:  
 25 Q. And what was the situation there, did it also

Page 92

1 involve patient contacts?  
 2 MS. PREDHAM:  
 3 A. Yes, it did.  
 4 CHAYTOR, Q.C.:  
 5 Q. And what happened?  
 6 MS. PREDHAM:  
 7 A. A patient who--we sent a panel letter to Dr.  
 8 Ganguly, but he didn't call this patient in.  
 9 She went back for her annual check up and when  
 10 he saw her there, he disclosed the information  
 11 to her then.  
 12 CHAYTOR, Q.C.:  
 13 Q. So there had been some gap in time between the  
 14 panel letter going out and Dr. Ganguly  
 15 relaying the information to the patient.  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. And at this point in time, what you've written  
 20 here, you certainly appear to be distressed.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And you sent that to a large number of people,  
 25 including the people you report to. What

Page 93

1 happened? Did anyone contact you, see how  
 2 you're doing with this, the level of stress  
 3 that you're obviously under and how this had  
 4 impacted you, did anyone come to you, speak to  
 5 you to see if you're okay to continue carrying  
 6 out what you had been asked to do.  
 7 MS. PREDHAM:  
 8 A. No, not from that perspective, but I guess,  
 9 you know, there was a lot of discussions on  
 10 how hard this all was. We had a new  
 11 department, you know, that was established and  
 12 we still, up to this point, we didn't have all  
 13 our staff in place yet. So it was a very  
 14 difficult time and everybody was going through  
 15 a difficult time.  
 16 CHAYTOR, Q.C.:  
 17 Q. And it appears this, then the first page of  
 18 this e-mail, it appears that there's to be a  
 19 meeting then, from Dr. Howell "re: 4:30  
 20 meeting today," same day. So was there a  
 21 meeting then held of the group to discuss this  
 22 issue and where things stand?  
 23 MS. PREDHAM:  
 24 A. I wasn't involved in a meeting.  
 25 CHAYTOR, Q.C.:

Page 94

1 Q. You weren't there?  
 2 MS. PREDHAM:  
 3 A. No.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and so after you sent out this e-mail,  
 6 did you have any response at all from anyone?  
 7 MS. PREDHAM:  
 8 A. Yes. I think I talked to several people on  
 9 that list and gave more information.  
 10 CHAYTOR, Q.C.:  
 11 Q. So you had several of the people that you  
 12 contacted phone you to get more information  
 13 about "what's going on here?"  
 14 MS. PREDHAM:  
 15 A. Or just to generally discuss that issue.  
 16 CHAYTOR, Q.C.:  
 17 Q. And who do you recall contacting you?  
 18 MS. PREDHAM:  
 19 A. I remember speaking to Ms. Smith and I  
 20 remember speaking to Ms. Pilgrim.  
 21 CHAYTOR, Q.C.:  
 22 Q. Anyone else?  
 23 MS. PREDHAM:  
 24 A. I don't recall.  
 25 CHAYTOR, Q.C.:

Page 95

1 Q. And if we could have, please, P-0424? This is  
 2 an e-mail about organizing a presentation and  
 3 it goes to Mr. Tilley, November 6th, 2006, we  
 4 understand, and "on Monday, November 20th, at  
 5 five p.m., Dr. Howell is organizing a  
 6 presentation by Heather Predham and Dr. Denic,  
 7 among others, on ER/PR review with a view to  
 8 having a presentation then to the executive on  
 9 November 21st." So what--were you involved  
 10 then in those presentations, and if so, what  
 11 was your role?  
 12 MS. PREDHAM:  
 13 A. I wasn't involved in presentation at all.  
 14 CHAYTOR, Q.C.:  
 15 Q. You didn't give any presentation?  
 16 MS. PREDHAM:  
 17 A. No.  
 18 CHAYTOR, Q.C.:  
 19 Q. And at this point in time, was it contemplated  
 20 that you might be involved in making a  
 21 presentation?  
 22 MS. PREDHAM:  
 23 A. I don't recall. I wasn't involved in at all.  
 24 CHAYTOR, Q.C.:  
 25 Q. And the discussion here was "who do you see

Page 96

1 giving the presentation to executive, Dr.  
 2 Denic and Heather Predham, plus legal  
 3 counsel." Do you recall any other discussion  
 4 around that?  
 5 MS. PREDHAM:  
 6 A. No. I know a presentation was given to  
 7 executive. I'm not sure of the date. It was  
 8 in November or December. I thought possibly  
 9 it was December. But I didn't give a  
 10 presentation.  
 11 CHAYTOR, Q.C.:  
 12 Q. You attended the presentation?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And if we could look, please, at P-2662? And  
 17 it appears November 16th that you're having  
 18 communication with Dr. Denic, "here are the  
 19 numbers. If you need anything else, call me."  
 20 And the subject line was briefing note to the  
 21 Minister and then you say "I'm not sure why  
 22 the subject came up as it did, so I've resent  
 23 it to make sure you have the right document."  
 24 Were you, at this point in time, also  
 25 preparing a briefing note for Minister



Page 97

1 Osborne?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and summary of the numbers, what is that  
 6 you're preparing for Dr. Denic?  
 7 MS. PREDHAM:  
 8 A. I think Dr. Denic wanted to have--I guess with  
 9 the timing, it must have been for his  
 10 presentation, because he did do a presentation  
 11 to executive. So I guess he wanted the latest  
 12 numbers.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and so the document that ultimately goes  
 15 to Minister Osborne later in November, the  
 16 numbers in that document, you would have been  
 17 the person who put those numbers together?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. And if we could have, please, P-2107? And  
 22 this is an e-mail from yourself, November  
 23 19th, 2006 to Ms. Elliott and Ms. Pilgrim.  
 24 "Hi, I met with Bev Carter, Ford Elms, Don  
 25 Cook, Nash Denic and Susan Bonnell on Friday

Page 98

1 afternoon. We reviewed the presentation for  
 2 Monday and it's very good and comprehensive.  
 3 As always, Bev's comments in the meeting were  
 4 a little bit alarmist in nature, but she is  
 5 only speaking about ER/PR testing at the  
 6 presentation." So first of all, I take it  
 7 this is your meeting to assist, at least, in  
 8 what will be presented. What was your role in  
 9 coordinating what's going to be presented?  
 10 MS. PREDHAM:  
 11 A. Well, it's related to--I just happen to go  
 12 into this meeting. They were already planning  
 13 on meeting, but Dr. Howell called me and told  
 14 me that when we went to executive on Tuesday,  
 15 he felt that I could, as I got here,  
 16 anticipate I'd be asked if I felt everything  
 17 was done that could be done in the lab as per  
 18 the external reviews. So you know, for me to  
 19 do that cold, I hadn't been involved in  
 20 anything like that. I expressed my concern  
 21 about that, and he suggested that these people  
 22 were getting together about the presentation  
 23 and maybe if I went over there, I could come  
 24 up with some idea on how I could, you know,  
 25 give that concern. So I invited myself to

Page 99

1 that meeting.  
 2 CHAYTOR, Q.C.:  
 3 Q. Okay, and so you went there to try and bring  
 4 yourself up to speed?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. What did you mean by "as always Bev" and I  
 9 take it you mean Dr. Carter, "comments in the  
 10 meeting were a little bit alarmist in nature"?  
 11 What had been your experience with Dr. Carter  
 12 prior to this to give you the impression that  
 13 she could tend to be a little alarmist?  
 14 MS. PREDHAM:  
 15 A. Well, she's very passionate about this and she  
 16 just tends to make broad statements from time  
 17 to time. I wasn't overly concerned obviously  
 18 because I didn't say what it was that was a  
 19 bit alarming, but you know, like she made that  
 20 comment back in August of '05 that there were  
 21 no positives or no negatives for a certain  
 22 period of time, but when we went and checked,  
 23 that wasn't accurate. And then, of course,  
 24 she resigned from the panel, but then she  
 25 still continued to go to the panel. So, you

Page 100

1 know, it was just a history of she would make  
 2 some comments and -  
 3 CHAYTOR, Q.C.:  
 4 Q. So what kind of comments had you ever heard  
 5 her make that you could classify as alarmist?  
 6 MS. PREDHAM:  
 7 A. Well, the fact that we had no positives for a  
 8 certain period of time.  
 9 CHAYTOR, Q.C.:  
 10 Q. So back on that?  
 11 MS. PREDHAM:  
 12 A. Yeah, back, that type of thing.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and other than that though, had you  
 15 heard her say anything that -  
 16 MS. PREDHAM:  
 17 A. Well, I can't think of anything right now.  
 18 CHAYTOR, Q.C.:  
 19 Q. And do you recall, what was she saying in the  
 20 meeting that you found to be a little bit  
 21 alarmist?  
 22 MS. PREDHAM:  
 23 A. Oh, I can't recall now.  
 24 CHAYTOR, Q.C.:  
 25 Q. Did it have anything to do with the current

Page 101

1 condition of the IHC lab?  
 2 MS. PREDHAM:  
 3 A. Probably not, because I wasn't concerned. If  
 4 I was concerned about it, I would have told  
 5 Ms. Elliott and Ms. Pilgrim.  
 6 CHAYTOR, Q.C.:  
 7 Q. But perhaps were you not concerned because you  
 8 thought maybe she's exaggerating or being  
 9 alarmist?  
 10 MS. PREDHAM:  
 11 A. I would never take it at face value. If  
 12 anybody said anything to me, I'd always have  
 13 to check into it, and you know, like we  
 14 checked into that period of time where she  
 15 said that there were no positives, I think.  
 16 I'd always have to check on it anyway.  
 17 CHAYTOR, Q.C.:  
 18 Q. You go on to write "but she's only speaking  
 19 about ER/PR testing at the presentation." So  
 20 might her comments have been about other  
 21 things in the IHC lab besides ER/PR?  
 22 MS. PREDHAM:  
 23 A. It could have been about anything. It could  
 24 have been, you know, the structure of the lab,  
 25 you know, any kind of broad issue like that.

Page 102

1 I have no idea. I have no memory of it, but I  
 2 wasn't overly concerned with whatever it was  
 3 she said.  
 4 CHAYTOR, Q.C.:  
 5 Q. And it's indicated here, as you've said, that  
 6 Dr. Howell has told you that he anticipates  
 7 you're going to have to speak on the issue of  
 8 whether everything was done that could have  
 9 been done, in terms of the external reviews  
 10 being, I guess, the recommendations carried  
 11 out, and so that's what prompted you to go to  
 12 the meeting?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. "He arranged for Nash to give me the summary  
 17 document of the reviewers' recommendations and  
 18 the lab actions. It has not been updated  
 19 since June and a lot of the recommendations  
 20 have ongoing next to it." Did that cause you  
 21 concern?  
 22 MS. PREDHAM:  
 23 A. Well, certainly, because it wasn't--you know,  
 24 I didn't know what had happened or what was  
 25 the state from June to now.

Page 103

1 CHAYTOR, Q.C.:  
 2 Q. And so what did you do to address that  
 3 concern? What further inquiries did you make?  
 4 MS. PREDHAM:  
 5 A. Well, that's what--Friday when I discussed it  
 6 with these people, we decided that Monday  
 7 morning, I think Dr. Elms was going to try--or  
 8 Dr. Carter, were going to try to get a CAP  
 9 audit and that we would walk through that and  
 10 see what we had or what we didn't have in  
 11 terms of that, and most of it, as I said here,  
 12 would be an audit of documentation, but that's  
 13 what we did and we didn't do that because I  
 14 don't think we had the time to get the copy of  
 15 the audit. There was some difficulty in  
 16 getting that where it was--it was late Friday  
 17 afternoon by the time this was over, and when  
 18 we came in on Monday morning, when we met, we  
 19 just went through the recommendations. So as  
 20 whatever was the recommendation, I noted to  
 21 myself where we were, what was completed and  
 22 what was still outstanding and what was being  
 23 worked on.  
 24 CHAYTOR, Q.C.:  
 25 Q. So this never took place? You never did the -

Page 104

1 MS. PREDHAM:  
 2 A. CAP audit.  
 3 CHAYTOR, Q.C.:  
 4 Q. And saying that, it wouldn't actually be CAP  
 5 audit.  
 6 MS. PREDHAM:  
 7 A. No, no  
 8 CHAYTOR, Q.C.:  
 9 Q. You would get the requirements for a CAP audit  
 10 and go through the lab and see, in fact -  
 11 MS. PREDHAM:  
 12 A. If we -  
 13 CHAYTOR, Q.C.:  
 14 Q. - if it could pass?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. And that didn't take place?  
 19 MS. PREDHAM:  
 20 A. No, and my recollection of that was it was  
 21 just because it was late Friday and we were  
 22 meeting first thing Monday morning.  
 23 CHAYTOR, Q.C.:  
 24 Q. And did you discuss with--I understood Mr.  
 25 Gulliver was tasked, and Mr.--or Dr. Cook and

Page 105

1 maybe by this point it's Dr. Denic, to see  
 2 that the recommendations were put in place.  
 3 Did you go and have any discussion as to  
 4 "well, this hasn't been updated since June.  
 5 Is this the most current document or have you  
 6 made any further progress?"  
 7 MS. PREDHAM:  
 8 A. Well, yes, that was the discussion when I met  
 9 with them, and so then when--you know, that  
 10 was--having a documentation that was--having a  
 11 document that was only updated in June was  
 12 really of no benefit to me, because I'd have  
 13 to see what was going on now. So then when we  
 14 couldn't get the CAP audit, I guess that was a  
 15 suggestion that came out of it. When we  
 16 couldn't get that, then we went through the  
 17 recommendations to see what it was and we  
 18 updated it.  
 19 CHAYTOR, Q.C.:  
 20 Q. Okay, and were there things that could be  
 21 updated?  
 22 MS. PREDHAM:  
 23 A. Oh yes, yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. So there were some things that were no longer

Page 106

1 ongoing, had been completed?  
 2 MS. PREDHAM:  
 3 A. There were things that were completed. That  
 4 were things that were in progress, but had  
 5 progressed further, and there were things that  
 6 they were having difficulty putting in place  
 7 or not difficulty, but you know, that needed  
 8 more work to put in place. In Quality, you  
 9 know, whenever we have an action plan, we've  
 10 always--you don't like putting ongoing there.  
 11 You want to put a bit more detail there. At  
 12 least you get some kind of state of the nation  
 13 view when you pick up a document.  
 14 CHAYTOR, Q.C.:  
 15 Q. And in terms of updating the document then,  
 16 was the recommendations list updated then in  
 17 November of 2006 to show what had, in fact,  
 18 been completed between June and November?  
 19 MS. PREDHAM:  
 20 A. I didn't do it. I had information--you know,  
 21 I did it for my benefit, my purpose only, and  
 22 our whole meeting that Monday morning was  
 23 solely for, you know, my purpose of going to  
 24 executive to say this, but I do believe it was  
 25 updated shortly after.

Page 107

1 CHAYTOR, Q.C.:  
 2 Q. So your purpose in doing this was so you would  
 3 know the current status of where things were  
 4 so you could speak to the issue when you had  
 5 to address executive?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And would you not though, in any event, have--  
 10 if you're the person who's going to have to  
 11 speak to you at executive, did you understand  
 12 then perhaps you have some responsibility to  
 13 keep on top of this and make sure that the  
 14 recommendations are being implemented?  
 15 MS. PREDHAM:  
 16 A. No, and at the time, I was concerned that I  
 17 was being asked to do this and I was going to  
 18 be asked this question, because you know, a  
 19 risk manager is, you know, a middle employee  
 20 and has no power and it was unusual that I  
 21 would have to be responsible for this because  
 22 I wasn't responsible for the entire  
 23 implementation of it. I was concerned and did  
 24 tell Ms. Elliott and Ms. Pilgrim of my  
 25 concern. So the feedback I got was that I

Page 108

1 could only go and say what I did say, which  
 2 was "I'm not involved in this review and I  
 3 took the recommendations and I reviewed the  
 4 recommendations and there are so many that are  
 5 in place and there's so many outstanding and  
 6 if everything goes on under Dr. Elms'  
 7 direction as is progressing, then they will  
 8 have completed all the recommendations."  
 9 CHAYTOR, Q.C.:  
 10 Q. And wouldn't there have been others at the  
 11 executive meeting and the presentation that  
 12 could have spoke to it? Why were you being  
 13 asked to do it, and if you had concerns in  
 14 doing it?  
 15 MS. PREDHAM:  
 16 A. I have no idea, but yes, Dr. Denic certainly  
 17 could have spoken to it. Mr. Gulliver was at  
 18 the executive meeting and Dr. Howell could  
 19 have spoken to it.  
 20 CHAYTOR, Q.C.:  
 21 Q. And in terms of the update to the  
 22 recommendations list, the one that you  
 23 received was June and so you're saying it was  
 24 updated then in November?  
 25 MS. PREDHAM:

Page 109

1 A. I updated it for myself. I think it got  
 2 updated. That was the only--up to that point,  
 3 that was the only time I ever even saw the  
 4 recommendation list.  
 5 CHAYTOR, Q.C.:  
 6 Q. And did you ever subsequently see any updated  
 7 versions?  
 8 MS. PREDHAM:  
 9 A. I think I did.  
 10 CHAYTOR, Q.C.:  
 11 Q. And in February 2007, the testing was re-  
 12 instituted and do you know, at that point in  
 13 time, how current the recommendations list  
 14 was? How most recent to February of 2007 that  
 15 recommendations list had been updated?  
 16 MS. PREDHAM:  
 17 A. No.  
 18 CHAYTOR, Q.C.:  
 19 Q. If we could look, please, at P-3061? And this  
 20 is further down the road, May 16th, 2007, and  
 21 you're e-mailing directly to Mr. Tilley.  
 22 "Here are the recommendations from the two  
 23 peer reviews, the one was updated June 2006.  
 24 There must be another one updated in November  
 25 after I went through, and I know Terry was

Page 110

1 updating it again for Oscar last week." And  
 2 the one that you provide then to Mr. Tilley -  
 3 MS. PREDHAM:  
 4 A. Yeah, my notes on it.  
 5 CHAYTOR, Q.C.:  
 6 Q. This is June of 2006?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. So in June of 2006--sorry, in May of 2007,  
 11 you're giving Mr. Tilley the June 30th, 2006  
 12 version and those notes on here, this is your  
 13 handwriting, is it?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. So you're saying this is notes you would have  
 18 made at the time of going through the  
 19 recommendation list in November?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CHAYTOR, Q.C.:  
 23 Q. And in terms of it being updated again, you  
 24 did handwritten notes on it in November, and  
 25 Mr. Gulliver was updating it in May of 2007?

Page 111

1 MS. PREDHAM:  
 2 A. I must have heard Mr. Gulliver say he was in  
 3 the process of updating it again.  
 4 CHAYTOR, Q.C.:  
 5 Q. And were you aware of any other updates in  
 6 between?  
 7 MS. PREDHAM:  
 8 A. No, and normally I wouldn't know. It was just  
 9 the fact that the one I had was dated in June  
 10 and I assumed they must have updated one after  
 11 I went through, and I heard Mr. Gulliver say  
 12 that he was updating it again.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and prior to the testing coming back in  
 15 February of 2007, did you do a CAP style  
 16 review or audit of the lab?  
 17 MS. PREDHAM:  
 18 A. I did not.  
 19 CHAYTOR, Q.C.:  
 20 Q. Do you know whether or not anyone did?  
 21 MS. PREDHAM:  
 22 A. I'm not aware of it.  
 23 CHAYTOR, Q.C.:  
 24 Q. And why not? If that's something you thought  
 25 would have been beneficial back in November of

Page 112

1 '06, why not do it before testing resumed?  
 2 MS. PREDHAM:  
 3 A. Because other than this in November, this  
 4 visit to executive, I wasn't involved in any  
 5 of the implementation of the recommendations  
 6 in the lab.  
 7 CHAYTOR, Q.C.:  
 8 Q. And why, on May 16th, 2007, are you involved  
 9 in sending the recommendations to Mr. Tilley?  
 10 MS. PREDHAM:  
 11 A. I distinctly remember this. I was walking up  
 12 Signal Hill and I got a page from Mr. Tilley  
 13 who was asking me if--he was looking for the  
 14 recommendations, the spreadsheet, and my  
 15 office is in Southcott Hall, which I was  
 16 almost up to the Battery actually, and so I  
 17 cut across the field and I went over and e-  
 18 mailed it to him, and I said "this is all I  
 19 have. I don't have anything else."  
 20 CHAYTOR, Q.C.:  
 21 Q. And that sticks out clearly in your mind?  
 22 MS. PREDHAM:  
 23 A. Well, that was an unusual circumstance, yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. To receive the phone call from Mr. Tilley?

Page 113

1 MS. PREDHAM:  
 2 A. Yeah, while I was walking up Signal Hill.  
 3 CHAYTOR, Q.C.:  
 4 Q. And he was phoning you directly?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And was that -  
 9 MS. PREDHAM:  
 10 A. Well, actually, you know, that's not quite  
 11 right. I think he ended up phoning Mrs.  
 12 Parsons at home and she paged me and I called  
 13 her back and she told me that Mr. Tilley was  
 14 looking for me because he was looking for a  
 15 document he couldn't find.  
 16 CHAYTOR, Q.C.:  
 17 Q. And what was the urgency on May 16th of him  
 18 having that document such that he had to track  
 19 Ms. Parsons down at home and track you down  
 20 walking up Signal Hill?  
 21 MS. PREDHAM:  
 22 A. I have no idea. I can't remember that. I  
 23 just remember that circumstance.  
 24 CHAYTOR, Q.C.:  
 25 Q. And if there had been a more updated version

Page 114

1 of the recommendations, I take it you would  
 2 have sent that to him?  
 3 MS. PREDHAM:  
 4 A. I told him at the time that I didn't have--  
 5 this was the only copy that I had and I didn't  
 6 know what else was gone on with it.  
 7 CHAYTOR, Q.C.:  
 8 Q. And did you tell him that the more appropriate  
 9 person to contact on it might be Dr. Denic or  
 10 Terry Gulliver?  
 11 MS. PREDHAM:  
 12 A. Yes, I did.  
 13 CHAYTOR, Q.C.:  
 14 Q. Why was it, in November of 2006, that you  
 15 suggested a CAP style audit take place?  
 16 MS. PREDHAM:  
 17 A. Well, when I met with those people, when they  
 18 were going through their presentation and they  
 19 were telling me what they were doing in that,  
 20 in the discussion, I was trying to figure out  
 21 how I was going to say that I felt comfortable  
 22 with what was going on in the lab. You know,  
 23 how would you have support to make that  
 24 comment, and during that discussion, I don't  
 25 think I came up with the CAP style audit, but

Page 115

1 I think one of--I think Dr. Elms actually came  
 2 up with that idea.  
 3 CHAYTOR, Q.C.:  
 4 Q. And if we could have, please, P-2108? And  
 5 this is the meeting of November 21st, 2006 of  
 6 the executive management and the guests  
 7 included Mr. Gulliver and yourself, Doctors  
 8 Denic, Cook, Elms, Laing and Mr. Boone, and  
 9 why did you understand Mr. Boone was present?  
 10 Were you involved in arranging to have him  
 11 there?  
 12 MS. PREDHAM:  
 13 A. No, I was not.  
 14 CHAYTOR, Q.C.:  
 15 Q. And do you understand what was his role? Why  
 16 was he there?  
 17 MS. PREDHAM:  
 18 A. I don't know. I can't remember actually now  
 19 why he was there.  
 20 CHAYTOR, Q.C.:  
 21 Q. And the following points were raised during  
 22 the presentation. "The organization cannot  
 23 speak publicly on the findings and  
 24 recommendations of the review because there is  
 25 currently a class action law suit ongoing.

Page 116

1 This information is protected under the  
 2 Evidence Act. Discussion ensued regarding the  
 3 need to share the experience with other  
 4 pathologists within the province. Dr. Howell  
 5 and Dan Boone to discuss further prior to  
 6 making any discussion to discuss the  
 7 reviewers' report with the provincial  
 8 pathologists." What do you recall being  
 9 discussed about that?  
 10 MS. PREDHAM:  
 11 A. I don't recall. I don't recall that  
 12 discussion.  
 13 CHAYTOR, Q.C.:  
 14 Q. And "Quality and Risk Management are confident  
 15 that the appropriate processes are in place.  
 16 Heather Predham"--I'm sorry, I should take you  
 17 up here first. "The organization needs to  
 18 establish a date when it will return to  
 19 testing mode. Returning to testing mode  
 20 requires the confidence of the oncologists and  
 21 medical staff. Executive agreed to extend  
 22 ER/PR testing at Mount Sinai for another  
 23 month. The Medical Advisory Committee is a  
 24 key group that confidence will need to be  
 25 restored. MAC has a major quality role and a

Page 117

1 direct line for reporting to the Board." What  
 2 do you understand the Medical Advisory  
 3 Committee's major quality role, what is it?  
 4 MS. PREDHAM:  
 5 A. Well, it is the approval body for all medical  
 6 policies and procedures that go in place and  
 7 any new, you know, Pharmacy and Therapeutics  
 8 reports to it, so any new process that  
 9 involves physicians or medical care would go  
 10 through that Board, Committee.  
 11 CHAYTOR, Q.C.:  
 12 Q. And do you know when you did your brief review  
 13 of the lab, in November '06, before you were  
 14 able to speak to the executive management  
 15 team, did you make inquiries as to where the  
 16 documentation phase, how many of the  
 17 recommendations, in terms of documentation,  
 18 standard operating procedures and policies  
 19 that were recommended be implemented? Did you  
 20 inquire as to what stage all of that was at?  
 21 MS. PREDHAM:  
 22 A. Well, I did as I went through the  
 23 recommendations.  
 24 CHAYTOR, Q.C.:  
 25 Q. And did you understand--what did you

Page 118

1 understand the stage to be with respect to  
 2 adopting a fixation policy?  
 3 MS. PREDHAM:  
 4 A. I can't remember right now. You know, I'd  
 5 have to go back and look and see whatever they  
 6 told me.  
 7 CHAYTOR, Q.C.:  
 8 Q. And are you able to determine that from your  
 9 handwritten notes on that document or would  
 10 you have it anywhere else?  
 11 MS. PREDHAM:  
 12 A. I don't know if I'd have it anywhere else. I  
 13 might be able to determine it there.  
 14 CHAYTOR, Q.C.:  
 15 Q. Okay, and in terms of standard operating  
 16 procedures for running the test, were you able  
 17 to see any standard operating procedures?  
 18 MS. PREDHAM:  
 19 A. I can't recall what I saw. They did have some  
 20 documentation in place and they had the  
 21 parameters much better documented. The  
 22 documentation was much better, or well,  
 23 couldn't be much worse, but it was--well,  
 24 there was a lot more documentation in the lab.  
 25 CHAYTOR, Q.C.:

Page 119

1 Q. I'm sorry, did you say it couldn't get much  
 2 worse?  
 3 MS. PREDHAM:  
 4 A. There was a lot of documentation in the lab  
 5 when I went down.  
 6 CHAYTOR, Q.C.:  
 7 Q. Yes, and did you just say it couldn't have  
 8 been much worse?  
 9 THE COMMISSIONER:  
 10 Q. Originally.  
 11 MS. PREDHAM:  
 12 A. Yes, I did.  
 13 CHAYTOR, Q.C.:  
 14 Q. And if--this here says, "Quality and risk  
 15 management are confident that the appropriate  
 16 processes are in place. Heather Predham  
 17 advised that there are some recommendations  
 18 from the review that have yet to be  
 19 implemented. It is important to ensure that  
 20 quality assurance monitoring processes are in  
 21 place and can be sustained and monitored into  
 22 the future. Documentation is of paramount  
 23 importance and must be monitored and  
 24 reviewed". So would you have, in giving your  
 25 presentation, indicated that quality and risk

Page 120

1 management are confident that the appropriate  
 2 processes are in place?  
 3 MS. PREDHAM:  
 4 A. No, because that doesn't fit with the rest of  
 5 the paragraph. What I said was what's in the  
 6 rest of the paragraph.  
 7 CHAYTOR, Q.C.:  
 8 Q. So you told the group that some  
 9 recommendations that, in fact, been  
 10 implemented, and you emphasized the importance  
 11 of ensuring that appropriate QA monitoring  
 12 processes are in place?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. So indicating that perhaps up to this point in  
 17 time, they weren't all in place?  
 18 MS. PREDHAM:  
 19 A. No, they weren't.  
 20 CHAYTOR, Q.C.:  
 21 Q. And did you have concern that there hadn't  
 22 been a process put in place to sustain and  
 23 monitor those processes into the future?  
 24 MS. PREDHAM:  
 25 A. The difficult thing with anything that you do

Page 121

1 in quality is making sure that you maintain it  
 2 and you have some process in place that you're  
 3 going to check and make sure that it is  
 4 maintained. So some kind of audit system in  
 5 place that you would go back and check.  
 6 Because, you know, for all best intentions,  
 7 you know, you have to plan for that at the  
 8 beginning to make sure that things are going  
 9 to carry on, and I just wanted to make sure,  
 10 okay, it's fine to put this documentation in  
 11 place, but you're going to have to make sure  
 12 that you go and check and make sure that it's-  
 13 -this is a new process, people have to be  
 14 trained in it, but you also have to make sure  
 15 it's being maintained.  
 16 CHAYTOR, Q.C.:  
 17 Q. And what did you understand that the lab had  
 18 in place as of November, 2006, to ensure that?  
 19 MS. PREDHAM:  
 20 A. Well, for the processes that were in, it was  
 21 very clear from the discussion that I had that  
 22 they were going to have to do regular audits,  
 23 documentation audits, that entire process.  
 24 CHAYTOR, Q.C.:  
 25 Q. And who would be overseeing that?

Page 122

1 MS. PREDHAM:  
 2 A. Well, ultimately it would be Dr. Denic and Mr.  
 3 Gulliver, but Dr. Elms was the IHC chief or  
 4 division chair, whatever the term is, and I  
 5 think at that process they were hiring a  
 6 quality person for the lab to assist in that  
 7 area.  
 8 CHAYTOR, Q.C.:  
 9 Q. Given that the recommendations hadn't been  
 10 updated since June of '06, and given that you  
 11 were able to determine that there were still a  
 12 number of things that needed to be done, and  
 13 perhaps the testing--it was being thought that  
 14 maybe within a month the testing could come  
 15 back on line, did you think perhaps someone  
 16 from your department, someone from risk  
 17 management, should get involved at this stage  
 18 to ensure that everything is in place prior to  
 19 the testing resuming?  
 20 MS. PREDHAM:  
 21 A. Other than this, we weren't asked to get  
 22 involved.  
 23 CHAYTOR, Q.C.:  
 24 Q. And did you from risk management and quality,  
 25 perhaps wear the quality hat here even more

Page 123

1 so, think that maybe that would be a good  
 2 idea, that someone needs to be involved from  
 3 your department?  
 4 MS. PREDHAM:  
 5 A. Well, there was also the process of setting up  
 6 a quality assurance committee in the lab and  
 7 the quality and safety leader that's linked to  
 8 the lab was involved in that.  
 9 CHAYTOR, Q.C.:  
 10 Q. And so that person was whom at that point in  
 11 time?  
 12 MS. PREDHAM:  
 13 A. Janet Laidley.  
 14 CHAYTOR, Q.C.:  
 15 Q. And she's in your department?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. So she was involved in helping oversee that  
 20 the recommendations were carried out?  
 21 MS. PREDHAM:  
 22 A. I'm not sure exactly what they were doing. I  
 23 know that she was working with Dr. Carter in  
 24 developing that committee and processes, and I  
 25 know they were involved with development of

Page 124

1 policies.  
 2 THE COMMISSIONER:  
 3 Q. Ms. Predham, did you in the process of going  
 4 into the laboratory, either your work  
 5 initially when you went to have a look at it  
 6 in that summer--late summer of 2005, or  
 7 thereafter form any view as to the  
 8 appreciation or lack of it within the  
 9 laboratory about the need for documentation,  
 10 for SOPs, for all that kind of thing that you  
 11 are saying is so important to be not only put  
 12 in place, but sustained?  
 13 MS. PREDHAM:  
 14 A. I found that they were all quite willing to do  
 15 that, they could see the purpose of it, and,  
 16 yes, we'll do that. I just found that in  
 17 other areas--you know, the past ten years of  
 18 working in quality, that you really need to  
 19 make sure people go back and check these  
 20 things. You can't just assume that you put  
 21 them in place and it's going to work out  
 22 forever.  
 23 THE COMMISSIONER:  
 24 Q. But let us say that the documentation that was  
 25 in place in the laboratory, you would concede

Page 125

1 was less than ideal?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 THE COMMISSIONER:  
 5 Q. But nobody seemed to have done anything about  
 6 it for a long period of time, so the question  
 7 which is raised in my mind then is whether  
 8 there was really an appreciation for the  
 9 desirability or the need for these documents?  
 10 MS. PREDHAM:  
 11 A. It was--I can certainly see your concern, and  
 12 it was--it was unusual circumstance because  
 13 the lab, in all my experience with doing  
 14 things in the lab, had top of the line  
 15 documentation, had very good auditing  
 16 processes. It was just like this area--it was  
 17 an oversight that the level of documentation  
 18 didn't equal other areas that I had seen, but  
 19 once it was brought to everybody's attention,  
 20 then it was, like, you're right, we should be  
 21 documenting these things and we should be  
 22 doing them, but it was a--I just found it  
 23 unusual when I first went into that lab  
 24 because I didn't expect that. I expected what  
 25 I had seen in other parts of the lab.

Page 126

1 CHAYTOR, Q.C.:  
 2 Q. And your opinion that the documentation  
 3 couldn't have been much worse, at the time did  
 4 you tell people that was your opinion, did you  
 5 tell others within Eastern Health that your  
 6 opinion was that this was pretty bad in terms  
 7 of what you were seeing for lack of  
 8 documentation?  
 9 MS. PREDHAM:  
 10 A. Everyone knew my concerns about documentation  
 11 in the lab.  
 12 CHAYTOR, Q.C.:  
 13 Q. Okay, and the test resumed then, as we said,  
 14 in February, 2007. Were you or the Quality  
 15 Initiatives Department involved in signing off  
 16 that the recommendations had been implemented  
 17 and everything was satisfactory to resume the  
 18 testing?  
 19 MS. PREDHAM:  
 20 A. No.  
 21 CHAYTOR, Q.C.:  
 22 Q. Nobody asked you to do that?  
 23 MS. PREDHAM:  
 24 A. No, that wouldn't be our responsibility  
 25 anyway. It would be the leadership team of

Page 127

1 the program.  
 2 CHAYTOR, Q.C.:  
 3 Q. And even given a situation such as this where  
 4 so many concerns had been involved, risk  
 5 management or quality would not have any  
 6 responsibility to ensure that, in fact, the  
 7 tests--things were ready to go?  
 8 MS. PREDHAM:  
 9 A. No, the leadership team is responsible for the  
 10 lab and they report to VP Medical, and that's  
 11 where the responsibility would lie.  
 12 CHAYTOR, Q.C.:  
 13 Q. And if we could look at, please, 3053, please.  
 14 THE COMMISSIONER:  
 15 Q. Ms. Chaytor, where we can find a spot, we'll  
 16 break for the morning break.  
 17 CHAYTOR, Q.C.:  
 18 Q. This is an e-mail exchange between yourself  
 19 and Dr. Howell, November 23rd, 2006, ER/PR  
 20 data clean up is the subject. "Are we able to  
 21 scrub datasheet on contact/conversions before  
 22 meeting with the minister today. Oscar". You  
 23 go back with a very good question, "This is  
 24 the latest summary of numbers. Is this okay.  
 25 I'm not sure what scrub means".

Page 128

1 MS. PREDHAM:  
 2 A. Even reading that sentence today, I still  
 3 don't know what the sentence means.  
 4 CHAYTOR, Q.C.:  
 5 Q. And did Dr. Howell ever tell you what he  
 6 meant?  
 7 MS. PREDHAM:  
 8 A. As far as I know, I basically called him and  
 9 said this is all I have, you know, so I'm not  
 10 really sure what you're talking about.  
 11 CHAYTOR, Q.C.:  
 12 Q. What you're asking me to do here?  
 13 MS. PREDHAM:  
 14 A. Yeah.  
 15 CHAYTOR, Q.C.:  
 16 Q. And did he--do you recall any response that  
 17 you received?  
 18 MS. PREDHAM:  
 19 A. Oh, he--well, I guess that's--no, I don't  
 20 recall any response.  
 21 CHAYTOR, Q.C.:  
 22 Q. So he's obviously--this is getting ready to  
 23 give the minister a briefing, and this would  
 24 be the start, I take it, of a briefing note to  
 25 the minister?



Page 129

1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And you see here in giving your total  
 5 retested, 939, you refer to those who are  
 6 converted, you refer to those who--the two  
 7 bolded groups that we've had some discussion  
 8 about in your evidence.  
 9 MS. PREDHAM:  
 10 A. Uh-hm.  
 11 CHAYTOR, Q.C.:  
 12 Q. That you felt could have been potentially  
 13 impacted, the 13 and the 9, and you talk about  
 14 the DCIS, the retro convertors, and the  
 15 patients who are deceased, and how many had  
 16 results received. If we could look then,  
 17 please, at P-3056. This is an e-mail then  
 18 from yourself again to--this time you include  
 19 Susan Bonnell, Leona Barrington, and Dr.  
 20 Howell, "Summary of numbers. See how this  
 21 looks". I don't think we have the attachment.  
 22 Let's try 3054. Your e-mail, and this is the  
 23 latest numbers to Pam Elliott and Debbie  
 24 Parsons, and then if we could try, 3056,  
 25 please. That's the same one, isn't it? 3054,

Page 130

1 again. Yes, this one does have the  
 2 attachment. This is how the latest looks, and  
 3 you'll see here, Ms. Predham, it looks fairly  
 4 similar except we don't use the word  
 5 "converted" any more, the word "no change" and  
 6 "change" are used.  
 7 MS. PREDHAM:  
 8 A. Dr. Howell never liked that term "converted".  
 9 CHAYTOR, Q.C.:  
 10 Q. So perhaps his reference to scrubbing included  
 11 cleaning up the use of that word?  
 12 MS. PREDHAM:  
 13 A. Could be.  
 14 CHAYTOR, Q.C.:  
 15 Q. Could be, okay, and what was his problem with  
 16 using the word "converted"?  
 17 MS. PREDHAM:  
 18 A. I can't recall now. I just remembered that he  
 19 didn't--he wondered who came up with that  
 20 term. He didn't like it.  
 21 CHAYTOR, Q.C.:  
 22 Q. And the group that you indicate as being  
 23 potentially impacted, the 13 are there. I  
 24 don't see any reference to the other 9 that  
 25 you had consistently referred to as also

Page 131

1 thinking had been impacted.  
 2 MS. PREDHAM:  
 3 A. No, you're right.  
 4 CHAYTOR, Q.C.:  
 5 Q. Do you recall why that got deleted from this?  
 6 MS. PREDHAM:  
 7 A. I have no idea.  
 8 CHAYTOR, Q.C.:  
 9 Q. And the section about the DCIS, I don't see  
 10 any reference to DCIS. We see originally  
 11 diagnosis revised, but no reference to  
 12 spelling out DCIS which you had in your  
 13 original draft, and do you recall how that  
 14 came up or why that would have been changed?  
 15 MS. PREDHAM:  
 16 A. No, I don't.  
 17 CHAYTOR, Q.C.:  
 18 Q. We do see DCIS up here mentioned, 52 of them.  
 19 So I take it that's 52 that had no change in  
 20 results, DCIS patients?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And if we could then, please, look at 3057,  
 25 and I believe this is the--you're sending to

Page 132

1 Ms. Pilgrim, briefing note, "Summary of  
 2 numbers", and if we could look at--this  
 3 appears to be the same as the document that I  
 4 showed you with those changes made, and if we  
 5 could look, please, at 314, page 10, and this  
 6 apparently is the final version that ends up  
 7 going to the minister, and did you draft this  
 8 version or somebody else?  
 9 MS. PREDHAM:  
 10 A. Somebody else would have done that.  
 11 CHAYTOR, Q.C.:  
 12 Q. And you provided the numbers, I take it?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And do you know who drafted it?  
 17 MS. PREDHAM:  
 18 A. It looks like something communications would  
 19 do up, but other than the fact that it looks  
 20 like that, I don't know.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, but otherwise the numbers are yours, the  
 23 939 results obtained and reviewed, 763, this  
 24 is the data you included, and the reference to  
 25 the group including those who are identified

Page 133

1 as being potentially impacted, those not  
 2 placed on Tamoxifen for their original  
 3 disease, that 13 are referred to. Are the  
 4 other nine that you had identified referred to  
 5 in there?  
 6 MS. PREDHAM:  
 7 A. No, they don't seem to be there.  
 8 CHAYTOR, Q.C.:  
 9 Q. And again the use of the word "converted" is  
 10 also not there. Is there any other change or  
 11 is this basically the information then that  
 12 you provided?  
 13 MS. PREDHAM:  
 14 A. It seems to be the information I provided.  
 15 CHAYTOR, Q.C.:  
 16 Q. And do you know why any changes were made  
 17 otherwise in the text of--apart from the  
 18 substance of what's here, why the changes were  
 19 made in the text and how it's laid out?  
 20 MS. PREDHAM:  
 21 A. Oh, I have no idea.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay. Thank you, Commissioner, this is a good  
 24 place for a break.  
 25 THE COMMISSIONER:

Page 134

1 Q. Take fifteen minutes.  
 2 (BREAK)  
 3 THE COMMISSIONER:  
 4 Q. Ms. Chaytor.  
 5 CHAYTOR, Q.C.:  
 6 Q. Thank you, Commissioner. P-3053, please,  
 7 Registrar. This is the first version that you  
 8 came up with, and you'll see here the detail  
 9 that you were giving at the time in terms of  
 10 what the various information meant, for  
 11 example, what confirmed negative meant. We've  
 12 already spoke to you about the nine that you  
 13 identified as being potentially impacted, and  
 14 then confirmed negative, 28, and you give some  
 15 detail as to what's meant by that, and then  
 16 confirmed positive, and you give detail as to  
 17 what is meant by that. Then if we look at  
 18 3054 again, a couple of hours later then you  
 19 have this version, and you'll see that the  
 20 detail around those confirmed positive, the  
 21 confirmed negative, that detail is also  
 22 omitted as well as what the--the detail around  
 23 the 341 and what was meant by the confirmed  
 24 negative. Do you know why did you--why did  
 25 you delete that information?

Page 135

1 MS. PREDHAM:  
 2 A. It must have been on the suggestion of  
 3 someone. It could have been Dr. Howell. I  
 4 can't remember.  
 5 CHAYTOR, Q.C.:  
 6 Q. And then if we look then, please, at P-0314  
 7 again, we'll see that again what goes forward  
 8 here is just confirmed negative 341, confirmed  
 9 negative from panel 28, confirmed positive 12,  
 10 without the detailed explanation that you had  
 11 given as to what that means?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. And along with the nine people not being  
 16 referenced either. So is that perhaps what it  
 17 meant to scrub the data?  
 18 MS. PREDHAM:  
 19 A. Oh, it--possibly. I recall cannot remember  
 20 now. I can remember asking the question, but  
 21 I can't remember.  
 22 CHAYTOR, Q.C.:  
 23 Q. And it would have been Dr. Howell that you  
 24 would have taken your direction from in terms  
 25 of what came out or stayed in in the briefing

Page 136

1 note for the minister?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. If we could have, please, P-0183. This is an  
 6 e-mail from Ms. Bonnell to a number of people,  
 7 including yourself and it refers to error  
 8 rate, "Attached to this e-mail, you will see  
 9 Heather's explanation of her error rate", and  
 10 it goes on to say, "We will begin the briefing  
 11 session with an explanation that this is an  
 12 unprecedented event because of the class  
 13 action, but that we believe we had an  
 14 obligation to inform the general public about  
 15 our outcomes and to provide the reporters with  
 16 an opportunity to fully understand the test  
 17 procedure and our actions since May, 2005, so  
 18 that they can report effectively on the issue.  
 19 However, because of the lawsuit, we are  
 20 limited in what we can talk about in terms of  
 21 causative factors. This will have to be dealt  
 22 with by the court. Secondly, we will not be  
 23 talking about any individual cases. This  
 24 information is protected and can only be  
 25 discussed between the patient and the care

Page 137

1 provider. Please review the attached. I am  
 2 very open to your concerns, suggestions,  
 3 ideas. Following our meeting with Dan, I  
 4 think I have a sense of how far we can go, but  
 5 Heather will be sharing all of this, as well  
 6 as the Q & A with him, and hope to get his  
 7 feedback as well". First of all, this is what  
 8 she attaches and you had sent to her on  
 9 December 7th, 2006, an explanation of the  
 10 error rate, and perhaps you can just take us  
 11 through that and explain what it is you came  
 12 up with?  
 13 MS. PREDHAM:  
 14 A. Well, it was embarrassing enough that Susan  
 15 sent this around to other people, let alone  
 16 that I'm having to explain this publicly, but--  
 17 and just from a math perspective, but Ms.  
 18 Bonnell had contacted me the day before and I  
 19 guess it was one of those days when you just--  
 20 you know, you have somebody saying this is  
 21 what I think, how about if we did this, how  
 22 about if we, you know, subtracted this group,  
 23 we did this, we did this, and I really wasn't  
 24 getting what she was saying, and I actually  
 25 had to go home and think about what she was

Page 138

1 saying as potential for an error rate. So  
 2 when we worked through that--this was--I  
 3 guess, this was our discussion, and I worked  
 4 through it with--you know, just to highlight  
 5 that, and shared it with her.  
 6 CHAYTOR, Q.C.:  
 7 Q. So who were you having the discussion with,  
 8 was it just with Ms. Bonnell?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. And how did the idea of an error rate even  
 13 come up with Ms. Bonnell?  
 14 MS. PREDHAM:  
 15 A. She felt very strongly with going out with  
 16 something substantive to the media at that  
 17 time.  
 18 CHAYTOR, Q.C.:  
 19 Q. Yes, and she's indicating, I guess, then to  
 20 you that they're going to want to know, the  
 21 public through the media are going to want to  
 22 know what was your error rate, how often did  
 23 you get the test right, how often did you get  
 24 the test wrong?  
 25 MS. PREDHAM:

Page 139

1 A. Exactly.  
 2 CHAYTOR, Q.C.:  
 3 Q. And so Ms. Bonnell was telling you that would  
 4 be a subject of some concern, she's  
 5 suspecting?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And so then you set out to try and figure out  
 10 an error rate?  
 11 MS. PREDHAM:  
 12 A. Well, we discussed it on the phone, you know,  
 13 what would you--what would you have under the  
 14 total number, and then we didn't know about  
 15 the results of deceased, so we'd have to  
 16 subtract them, and then, of course, we had  
 17 other issues that we had into it, so you'd  
 18 have to take them out, and--we just had that  
 19 discussion and I can remember that afternoon,  
 20 I just--I couldn't keep track of what she was  
 21 saying. So I said I'm going to have to get  
 22 back to you, and I really couldn't do it  
 23 justice at work, so I went home and sat down  
 24 and tried to think about what she was saying,  
 25 or what she was doing, and this is what -

Page 140

1 CHAYTOR, Q.C.:  
 2 Q. So are you saying it was Ms. Bonnell trying to  
 3 come up with--and was giving you these  
 4 figures, or -  
 5 MS. PREDHAM:  
 6 A. Oh, no, we were just--you know, we were  
 7 talking about it, and I would say these are  
 8 the numbers that I have, and then--so then we  
 9 would talk about it, you know, well--and I  
 10 most likely brought up the fact that the  
 11 deceased aren't all retested. So, you know,  
 12 how will be take that. So then we just talked  
 13 through that that way.  
 14 CHAYTOR, Q.C.:  
 15 Q. And did anyone else assist you in coming up  
 16 with this error rate?  
 17 MS. PREDHAM:  
 18 A. Oh, no.  
 19 CHAYTOR, Q.C.:  
 20 Q. This is just you and Ms. Bonnell?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And so you start off with 939, the original  
 25 identified negatives, 2760 total number of

Page 141

1 cases. Now did you have any concerns using  
 2 that as your denominator?  
 3 MS. PREDHAM:  
 4 A. No, I didn't--I can't remember why we picked  
 5 that one as opposed to any other, but, no.  
 6 CHAYTOR, Q.C.:  
 7 Q. And given the fact that not all of the cases  
 8 had been retested -  
 9 MS. PREDHAM:  
 10 A. And I can say to you right now, even before we  
 11 go through it all -  
 12 CHAYTOR, Q.C.:  
 13 Q. Yes.  
 14 MS. PREDHAM:  
 15 A. You know, the gist of me seeing this when I  
 16 typed it out, and seeing it, and thinking  
 17 about it, this is when it really struck home  
 18 that the numbers I had were not the numbers to  
 19 do any type of error rate with, and like I  
 20 mentioned to you a couple of times before,  
 21 this was--you know, it really struck home then  
 22 that this was not a picture of conversions or  
 23 anything because it was the way people were  
 24 treated, and there were so many other factors,  
 25 that there wasn't any consistency with how it

Page 142

1 was applied, it was very individual. So, you  
 2 know--and again this was very superficial,  
 3 just myself and Ms. Bonnell talking, and  
 4 that's why I was a little bit perturbed that  
 5 she circulated it around to people.  
 6 CHAYTOR, Q.C.:  
 7 Q. So even when you were doing it--doing this,  
 8 you realized this was not an appropriate or  
 9 accurate way to do it?  
 10 MS. PREDHAM:  
 11 A. Well, I did it, and then when I--I was  
 12 thinking about it, and, you know, subsequently  
 13 I said these are the wrong numbers, these are  
 14 not the numbers to be figuring out what an  
 15 error rate is.  
 16 CHAYTOR, Q.C.:  
 17 Q. And tell us then--tell us which of the  
 18 numbers, or what is it about this that caused  
 19 you concern upon further reflection upon it?  
 20 MS. PREDHAM:  
 21 A. Well, for one issue, taking the deceased out,  
 22 not having the complete number of the deceased  
 23 because, you know, that--you're not getting a  
 24 true picture there, the fact that you don't  
 25 know--the fact that you're going by clinical

Page 143

1 recommendation of change. So here we have 369  
 2 confirmed negative, but someone can be  
 3 confirmed negative and actually have a change.  
 4 They could have been 0, and come back as 5,  
 5 and whatever on the PR, but they're still  
 6 confirmed negative, given the circumstances of  
 7 their case. So it really wasn't giving a--you  
 8 couldn't say that they didn't change, and  
 9 you'd also need to have input from the lab  
 10 from a technical side that what is more  
 11 concerning to them, is it a 0 to a 5, is it a  
 12 0 to a 25, is it a 0 to a 90, or if 30 percent  
 13 change is the same from 0 to 30, is it the  
 14 same concern level then from 10 to 40, or is  
 15 it the same concern level from 60 to 90,  
 16 because that's the other aspect of it. We  
 17 hadn't seen any--you know, there were some  
 18 positives who did change in the number, but  
 19 what does that mean.  
 20 CHAYTOR, Q.C.:  
 21 Q. And at what point did you realize this? On  
 22 December 7th, 2006, after you've had some  
 23 quiet and time to get it clear in your head,  
 24 the next morning you shoot it off to Ms.  
 25 Bonnell. So I take it at the time you did it,

Page 144

1 you were confident enough with what you had  
 2 done to share it with her, you didn't just  
 3 scrap it and say, look, Ms. Bonnell, we can't  
 4 do this?  
 5 MS. PREDHAM:  
 6 A. Well, it was--this was myself and Susan  
 7 talking about an error rate. This was not--  
 8 this was not something--I didn't think this  
 9 was going farther than her and me and we would  
 10 carry on this conversation, but then when she  
 11 circulated it around to everybody and it  
 12 looked like, you know--I was concerned that  
 13 somebody would go out with these numbers or  
 14 something because I had said them, but I  
 15 started to get--as I worked through this, I  
 16 started getting concerned that this was really  
 17 not giving the picture, this was really giving  
 18 a false picture.  
 19 CHAYTOR, Q.C.:  
 20 Q. So while you were working through it, but you  
 21 still nonetheless provided it to Ms. Bonnell?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And what did you understand Ms. Bonnell was

Page 145

1 going to do with it?

2 MS. PREDHAM:

3 A. Oh, I thought we would just continue to talk

4 about it at that time. I didn't realize she

5 was going to circulate it around to people.

6 CHAYTOR, Q.C.:

7 Q. So you realized then just a few minutes later,

8 within the same hour, she does share it with a

9 larger group. So what did you do about that?

10 MS. PREDHAM:

11 A. I believe I called her after that.

12 CHAYTOR, Q.C.:

13 Q. Did you e-mail the group and say ignore that

14 document, I really don't think you can put any

15 reliance in it, here are the issues that I've

16 identified?

17 MS. PREDHAM:

18 A. No, I don't--I didn't e-mail anybody. I know

19 I did talk to--I brought up my concerns on

20 numerous times with Dr. Howell and with Susan.

21 CHAYTOR, Q.C.:

22 Q. And in terms of the overall group that we see

23 here, was there actually a meeting of this

24 group around this date or shortly thereafter

25 in preparation for the media technical

Page 146

1 briefing?

2 MS. PREDHAM:

3 A. I think she referenced a meeting. I really

4 can't remember any meeting.

5 CHAYTOR, Q.C.:

6 Q. You don't remember a meeting to discuss the--

7 getting ready for the media technical

8 briefing?

9 MS. PREDHAM:

10 A. No.

11 CHAYTOR, Q.C.:

12 Q. And do you recall a conference call then or

13 some other means of communication amongst the

14 group members?

15 MS. PREDHAM:

16 A. I have a very clear memory of being in the

17 parking lot of Southcott Hall on a cell phone

18 talking to Ms. Bonnell and Dr. Howell about

19 numbers, and I was explaining this concern of

20 mine that the numbers that came from the panel

21 did not reflect what was actually going on

22 with the numbers, so it--because of the

23 clinical impact of these numbers, it really

24 wasn't giving an accurate picture, it wasn't

25 giving an error rate as such, it wasn't giving

Page 147

1 that kind of perception because as we can see

2 with the retro convertors, you weren't

3 identifying all ones that retro converted, it

4 was only the ones that had a clinical impact.

5 CHAYTOR, Q.C.:

6 Q. But those were the same numbers you gave to

7 the minister just the week before?

8 MS. PREDHAM:

9 A. Yes, but that was the only numbers I had.

10 CHAYTOR, Q.C.:

11 Q. So now you have a concern about the numbers.

12 Which numbers are now of concern to you?

13 MS. PREDHAM:

14 A. It wasn't the numbers that I was concerned

15 about, it was using the numbers. It was

16 coming out and saying this is the error rate

17 for the test and using the numbers from the

18 panel as a calculator for the error rate of

19 the test.

20 CHAYTOR, Q.C.:

21 Q. Okay, and that was because why?

22 MS. PREDHAM:

23 A. Because--because, as I explained, the numbers

24 that were listed out were what happened to

25 people, what happened to individual people,

Page 148

1 based on their clinical presentation and the

2 disease process that they had, but it wasn't

3 based on from a technical perspective what

4 actually happened. If somebody was zero/zero

5 and then came back as 2/2, then as far as I

6 understand it from a lab perspective, that's

7 very significant, that is a conversion because

8 it's gone from no positivity to some

9 positivity.

10 CHAYTOR, Q.C.:

11 Q. Well, there's 28 of those.

12 MS. PREDHAM:

13 A. Yes, but in our results, they are confirmed

14 negative.

15 CHAYTOR, Q.C.:

16 Q. Yes, but if you're concerned that to give the

17 full picture, you just add in the 28, wouldn't

18 you?

19 MS. PREDHAM:

20 A. But there was lots of ones that changed a

21 little bit. These are my concerns with that,

22 you know, and I'm not a lab person, I'm not an

23 oncologist, but when I saw that the numbers

24 that I was doing from the panelling--up to

25 that point they had never been used to

Page 149

1 calculate an error rate before.  
 2 CHAYTOR, Q.C.:  
 3 Q. So is it just the wording of an error rate  
 4 that's of concern to you, or--you have numbers  
 5 and you're confident enough in your numbers to  
 6 provide them to the minister.  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. Just a week before. So the numbers would  
 11 suggest how many had changes in their  
 12 treatment, how many required--had changes in  
 13 their results based on your numbers.  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. Of what went forward. So what's wrong with  
 18 figuring out, well, how many out of who we  
 19 retested had changes in their results, how  
 20 many out of who we retested had changes in  
 21 their treatment?  
 22 MS. PREDHAM:  
 23 A. There's no trouble with saying how many had  
 24 changes in their treatment.  
 25 CHAYTOR, Q.C.:

Page 150

1 Q. Okay.  
 2 MS. PREDHAM:  
 3 A. There was no problem there, but saying that  
 4 this test had an error rate of that, my  
 5 concern was that it didn't accurately reflect  
 6 that.  
 7 CHAYTOR, Q.C.:  
 8 Q. Because your concern was it might be greater  
 9 than the number of people who had changes in  
 10 their results because there's the 28 confirmed  
 11 negatives which, in fact, from a technical lab  
 12 perspective, really the test change as well/  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. So you could add that in and calculate that as  
 17 well?  
 18 MS. PREDHAM:  
 19 A. Yes, and like as we've seen with the retro  
 20 convertors, there was more retro convertors  
 21 than four.  
 22 CHAYTOR, Q.C.:  
 23 Q. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And when did -

Page 151

1 THE COMMISSIONER:  
 2 Q. Let me understand that. What you're raising  
 3 here, you're saying if you want to look at  
 4 this from the perspective of the success of  
 5 the procedure of determining positivity, then  
 6 you cannot use the clinical decisions to do  
 7 that?  
 8 MS. PREDHAM:  
 9 A. Exactly.  
 10 THE COMMISSIONER:  
 11 Q. Is that -  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 THE COMMISSIONER:  
 15 Q. So from your perspective, one would have to  
 16 look at presumably the numbers received--  
 17 produced by Mount Sinai, and some presumably  
 18 somebody else somewhere along the way would  
 19 have to calculate what is a significant change  
 20 in those numbers, would going from 12 percent  
 21 to 13 percent be a real change in the  
 22 scientific world, and in the same way would in  
 23 the scientific world going from 12 percent to  
 24 90 percent be a change which would not  
 25 necessarily mean a change in treatment in your

Page 152

1 world?  
 2 MS. PREDHAM:  
 3 A. Right.  
 4 THE COMMISSIONER:  
 5 Q. Okay.  
 6 MS. PREDHAM:  
 7 A. And this was the problem because it was okay  
 8 to give the numbers as this is the result of  
 9 the panel and you do that, but when people  
 10 started thinking, well, okay, we can calculate  
 11 an error rate from that, and it really struck  
 12 home after I went through that process and  
 13 started thinking about it, that that's not the  
 14 way to calculate an error rate on this. I had  
 15 had those preliminary discussions with the  
 16 Health Research Unit at MUN, and, you know,  
 17 that's the type of--that type of analysis is  
 18 the type of analysis to determine what an  
 19 error rate was.  
 20 CHAYTOR, Q.C.:  
 21 Q. And you could do, I guess, two calculations.  
 22 One for technical, and one for clinical.  
 23 MS. PREDHAM:  
 24 A. Oh, yes, exactly, and that's what you would  
 25 need to do because you would need to know the

Page 153

1 impact on the patients, but then you'd also  
 2 need to know the accuracy of the test. So  
 3 really--so it's fine, the numbers for the  
 4 panelling is fine for the minister, this is  
 5 the impact on the patients or whatever, but  
 6 the numbers side of it, calculating an error  
 7 rate or doing that type of analysis, that  
 8 wouldn't reflect it. That would just be--you  
 9 know, it wouldn't be accurate.

10 CHAYTOR, Q.C.:

11 Q. And you had all the--assuming, of course,  
 12 there's been other issues with the numbers  
 13 identified since, but to the best of your  
 14 ability or knowledge in November and December  
 15 of 2006, your numbers were accurate at that  
 16 point?

17 MS. PREDHAM:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. And you had all the numbers then that--or all  
 21 the data that you would need to be able to  
 22 calculate the two different clinical--  
 23 clinically, I guess, what would be determined  
 24 to be an error rate, and technically what  
 25 would be determined to be an error rate?

Page 154

1 MS. PREDHAM:

2 A. Well--that was well beyond my skill set  
 3 because, you know, there were certain decision  
 4 that would have to be made from input from the  
 5 technical side on exactly what is a  
 6 significant change from them. You could go--I  
 7 remember at the time thinking that you  
 8 possibly could go for the no expressors and  
 9 then group them into low expressors, and then  
 10 group them into high expressors, and the low  
 11 expressors would be 0 to 10, and then you  
 12 could do a rate of change between those three  
 13 groups, but that was very preliminary, and  
 14 also we--you know, it really struck home then  
 15 that you would really have to identify the  
 16 deceased, you'd have to get the rest of the  
 17 deceased retested because, you know, they may  
 18 have a greater rate of change, or you don't  
 19 know until you looked at it all.

20 CHAYTOR, Q.C.:

21 Q. And in November and December when this was  
 22 being discussed, you were cognizant of all  
 23 those issues?

24 MS. PREDHAM:

25 A. Yes. Well, this is when it was all coming

Page 155

1 together in my mind that--you know, when--it  
 2 was always thought--Dr. Cook and I talked  
 3 numerous times how we had to get the analysis  
 4 done at the end of the day, and--you know, so  
 5 that's when I went over to the Health Research  
 6 Unit and had some discussions there, and he  
 7 also--and I think I mentioned this earlier, he  
 8 thought there may be a possibility that you  
 9 could do some predictive modelling. So if you  
 10 had a test result in '97 and you knew that  
 11 things had changed to increase positivity  
 12 levels over those seven/eight years, you could  
 13 calculate in some kind of statistical way what  
 14 a predicted value based on those changes would  
 15 be if it was retested, and then compare that  
 16 to the actual value. So there was some  
 17 statistical analysis that could be done.

18 CHAYTOR, Q.C.:

19 Q. You had those discussions when?

20 MS. PREDHAM:

21 A. In May of '06.

22 CHAYTOR, Q.C.:

23 Q. In May of '06.

24 MS. PREDHAM:

25 A. So the--the other--the other part of it as

Page 156

1 well is that the other dynamic is that you had  
 2 a group that we really hadn't identified or  
 3 nailed down very well in the panel, that, you  
 4 know, could--would not have been offered  
 5 Tamoxifen originally because they were--and I  
 6 can't remember if they were pre or post  
 7 menopausal, one or the other group was not a  
 8 candidate for Tamoxifen in the '97/'98, and  
 9 also some people couldn't take Tamoxifen, but  
 10 now they were recommended for treatment  
 11 because the aromatase inhibitors were there.  
 12 So I guess at this time when Susan sent this  
 13 out because, of course, I thought it was a  
 14 preliminary discussion and then she sent it  
 15 out to everybody, this is what my concern was.  
 16 It's okay to go out with, you know, what  
 17 you're going out with, but don't use it to do  
 18 something else.

19 CHAYTOR, Q.C.:

20 Q. And you had also come up with the number of  
 21 those patients too, how many could now avail  
 22 of the treatment because the aromatase  
 23 inhibitors was an option?

24 MS. PREDHAM:

25 A. No, I hadn't come up with that.

Page 157

1 CHAYTOR, Q.C.:

2 Q. So who was the 13 people, who because of--is

3 that because of the difference in the change

4 of positivity?

5 MS. PREDHAM:

6 A. Yes.

7 CHAYTOR, Q.C.:

8 Q. Or definition of positivity?

9 MS. PREDHAM:

10 A. The definition of what positive was.

11 CHAYTOR, Q.C.:

12 Q. And I take it then if you knew all that in May

13 of '06 or started--had had discussions at that

14 point, why did you bother doing this at all on

15 December 7th '06 and trying to come up with an

16 error rate?

17 MS. PREDHAM:

18 A. Well, I guess, you know, when Susan was

19 talking--it was after--it was after I went

20 through this process that it actually struck

21 home that you cannot do--you can't do it with

22 this, you can't attempt to do it with this

23 because there were so many influences on each

24 of these groups and these numbers.

25 CHAYTOR, Q.C.:

Page 158

1 Q. And after Susan sent that out to all the

2 group, you didn't--you didn't e-mail them or

3 have any communications with all the

4 individuals here to ensure that "I have

5 serious concerns about being able to calculate

6 any error rate, and certainly not on the basis

7 of what I've done here"?

8 MS. PREDHAM:

9 A. Well, I followed up with Susan and Dr. Howell.

10 CHAYTOR, Q.C.:

11 Q. But not the others?

12 MS. PREDHAM:

13 A. No.

14 CHAYTOR, Q.C.:

15 Q. You say you had a cell phone conversation with

16 Dr. Howell and Susan Bonnell?

17 MS. PREDHAM:

18 A. Yes.

19 CHAYTOR, Q.C.:

20 Q. On this same day?

21 MS. PREDHAM:

22 A. I'm not sure when that was. It was in the

23 evening, it was dark, and I remember it was in

24 result of my concerns that you couldn't do

25 that, and that Ms. Bonnell wanted to go out

Page 159

1 with a number, and that was when Dr. Howell

2 said that the whole point of us doing this

3 process was to offer people Tamoxifen if they

4 weren't already a candidate. So how about if

5 we just go out with the 117, these are the

6 people that we offered treatment.

7 CHAYTOR, Q.C.:

8 Q. And when did that get said by Dr. Howell?

9 MS. PREDHAM:

10 A. It was during that phone message, that phone

11 call that I had.

12 CHAYTOR, Q.C.:

13 Q. And so Susan Bonnell and Dr. Howell are

14 together on the phone?

15 MS. PREDHAM:

16 A. They were either together or it was a three

17 way call. I just remember being on the phone

18 with both of them.

19 CHAYTOR, Q.C.:

20 Q. Okay, and were there others then perhaps also

21 on the call?

22 MS. PREDHAM:

23 A. Could have been. I don't recall. I just

24 remember the two of them.

25 CHAYTOR, Q.C.:

Page 160

1 Q. So there was some sort of group discussion.

2 Whether it involved three of you or more,

3 you're not sure. You can't remember at this

4 point?

5 MS. PREDHAM:

6 A. No.

7 CHAYTOR, Q.C.:

8 Q. And it's during that discussion that Dr.

9 Howell says we'll just go out and concentrate

10 on the 117 number?

11 MS. PREDHAM:

12 A. Yes, because that was--the purpose that we did

13 the retesting in the first place was to offer

14 people treatment.

15 CHAYTOR, Q.C.:

16 Q. And did you tell Dr. Howell your concerns

17 about the 117 number?

18 MS. PREDHAM:

19 A. My concerns?

20 CHAYTOR, Q.C.:

21 Q. What did you understand the 117 number was?

22 MS. PREDHAM:

23 A. The concerns were people that were offered

24 treatment.

25 CHAYTOR, Q.C.:



Page 161

1 Q. By whom?  
 2 MS. PREDHAM:  
 3 A. By the--when they went through the panelling.  
 4 CHAYTOR, Q.C.:  
 5 Q. And it did not include all of the people who  
 6 required a change in their treatment?  
 7 MS. PREDHAM:  
 8 A. Well, they--everyone knew the limitations for  
 9 these numbers. I mean, that was well known,  
 10 this was the results of the panelling. This  
 11 is what the panel decided. It was not  
 12 anything else outside the panelling that  
 13 occurred.  
 14 CHAYTOR, Q.C.:  
 15 Q. Was it well known to those making the  
 16 decision, including Dr. Howell, that the 117  
 17 did not include all of the patients who  
 18 required a change in treatment, only those  
 19 that came before the panel and had yet to be  
 20 offered a change in treatment?  
 21 MS. PREDHAM:  
 22 A. I would think, but I can't be sure right now  
 23 what he knew or what he didn't know.  
 24 CHAYTOR, Q.C.:  
 25 Q. And did you ever clearly articulate that to

Page 162

1 him?  
 2 MS. PREDHAM:  
 3 A. I can't remember at that time clearly  
 4 articulating it.  
 5 CHAYTOR, Q.C.:  
 6 Q. Well, did you have any concern yourself then,  
 7 "well, if the decision is now made, they're  
 8 going with the 117 because the whole focus was  
 9 who needs a change in treatment," did you have  
 10 any concern, "well, that's not really accurate  
 11 because I know there's more than 117. That's  
 12 just the ones that the panel determined needed  
 13 a change."  
 14 MS. PREDHAM:  
 15 A. I don't think that crossed my mind at the  
 16 time.  
 17 CHAYTOR, Q.C.:  
 18 Q. But all of the information and all the factors  
 19 about why you couldn't do an error rate, that  
 20 crossed your mind?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. What about forgetting about calling it an  
 25 error rate and just giving all the numbers,

Page 163

1 was that discussed? Like "let's just tell  
 2 people what we know."  
 3 MS. PREDHAM:  
 4 A. Well, the concern--you know, this was outside  
 5 my comfort level. We had never gone out  
 6 before when we had law suits and talked to the  
 7 media, and I think Susan has identified that  
 8 there, but she wanted to go out with a number,  
 9 and you know, from my--it was outside my  
 10 comfort level. This was something we had  
 11 never done before.  
 12 CHAYTOR, Q.C.:  
 13 Q. And why was it outside your comfort level?  
 14 What was your concern?  
 15 MS. PREDHAM:  
 16 A. Because whenever we had a statement of claim,  
 17 we never spoke to the media.  
 18 CHAYTOR, Q.C.:  
 19 Q. And why is that?  
 20 MS. PREDHAM:  
 21 A. That's the way it always was before I became  
 22 risk manager and that's the way it always  
 23 progressed, that whenever there was a  
 24 statement of claim, that we--it was before the  
 25 courts and any information that would be

Page 164

1 released would be released through that  
 2 process.  
 3 CHAYTOR, Q.C.:  
 4 Q. Was there a decision made that all of the  
 5 numbers would not be released?  
 6 MS. PREDHAM:  
 7 A. I don't remember that. All I remember is that  
 8 "why don't we go out with that 117?"  
 9 CHAYTOR, Q.C.:  
 10 Q. And in going with just the 117, did you  
 11 understand that there wouldn't be reference to  
 12 the other numbers, including the 300 and  
 13 whatever number of people with changed  
 14 results?  
 15 MS. PREDHAM:  
 16 A. I must have, if I was--you know, I knew that  
 17 was the number we were going out with, then I  
 18 would have known that that was the only number  
 19 we were going out with.  
 20 CHAYTOR, Q.C.:  
 21 Q. That's the only number, okay. And so you were  
 22 informed about that.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

Page 165

1 Q. And part of the discussions in leading up to  
 2 that decision being made?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And who else was part of that, besides Dr.  
 7 Howell and yourself and Susan Bonnell?  
 8 MS. PREDHAM:  
 9 A. Well, I assume Dr. Denic and Dr. Laing were,  
 10 because they were involved in that, but like I  
 11 said, that's my memory of the 117 and I've  
 12 racked my brain about that, of course, for  
 13 obvious reasons, and that's my only memory is  
 14 that telephone call.  
 15 CHAYTOR, Q.C.:  
 16 Q. You gave all the numbers to--well, all but  
 17 probably the nine, to Minister Osborne on  
 18 November 23rd.  
 19 MS. PREDHAM:  
 20 A. Um-hm.  
 21 CHAYTOR, Q.C.:  
 22 Q. Wasn't anybody thinking "well, this is a  
 23 briefing note for the Minister. He has to  
 24 stand up in the House of Assembly. He could  
 25 very well be asked questions publicly on this

Page 166

1 issue. He could use the numbers publicly?"  
 2 MS. PREDHAM:  
 3 A. Ms. Chaytor, the only aspect I had was, again,  
 4 it was outside my comfort level. Whenever we  
 5 had a Statement of Claim, we didn't talk to  
 6 the media.  
 7 CHAYTOR, Q.C.:  
 8 Q. And the reason for that is because you don't  
 9 want to say or do anything that could  
 10 undermine your defence to the action?  
 11 MS. PREDHAM:  
 12 A. That's your way of putting it. Mine is just  
 13 that anything that goes on to the Court, it  
 14 goes through the Court process and gets  
 15 released that way.  
 16 CHAYTOR, Q.C.:  
 17 Q. And was that part of the reluctance to saying  
 18 anything publicly, because you might say  
 19 something that could undermine your defence?  
 20 MS. PREDHAM:  
 21 A. That was always our practice.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, and was -  
 24 MS. PREDHAM:  
 25 A. We had -

Page 167

1 CHAYTOR, Q.C.:  
 2 Q. - and was that part of the thinking though?  
 3 There must be some thought process "well, it's  
 4 before the Courts. We can't talk on it."  
 5 Well, why? There must be some thought as to  
 6 why that's your position.  
 7 MS. PREDHAM:  
 8 A. That was--you know, that's just the way things  
 9 are done. You don't speak to the media if  
 10 something is ahead of the court because things  
 11 get released through the Court process. That  
 12 was--you know, that was just the way things  
 13 are.  
 14 CHAYTOR, Q.C.:  
 15 Q. And you never questioned why that's the way  
 16 things are?  
 17 MS. PREDHAM:  
 18 A. No.  
 19 CHAYTOR, Q.C.:  
 20 Q. And did you understand or were you ever of the  
 21 understanding or of the opinion that part of  
 22 the reason at least for that would be we  
 23 wouldn't want to do something to undermine our  
 24 defence?  
 25 MS. PREDHAM:

Page 168

1 A. Well, I guess that makes sense, but you know,  
 2 the thinking since I've got into this position  
 3 and was well established before that is if  
 4 something is in the courts, you don't make  
 5 comment in the media. If anything is being  
 6 released, it gets released through the Court  
 7 process.  
 8 CHAYTOR, Q.C.:  
 9 Q. And you'd never had a situation like this  
 10 before though?  
 11 MS. PREDHAM:  
 12 A. No.  
 13 CHAYTOR, Q.C.:  
 14 Q. This was unprecedented?  
 15 MS. PREDHAM:  
 16 A. Yes, and I think even Susan said that. I'd  
 17 never--it was outside my comfort level. It  
 18 had never come up before.  
 19 CHAYTOR, Q.C.:  
 20 Q. And so if you'd had your preference, in  
 21 December 2006, would there have been a media  
 22 briefing at all to disclose any information?  
 23 MS. PREDHAM:  
 24 A. My preference, my comfort level, from what I  
 25 dealt with and anything else that had a

Page 169

1 statement of claim, we would not have gone to  
 2 the media at that time.  
 3 CHAYTOR, Q.C.:  
 4 Q. So you would have continued to say "the matter  
 5 is before the courts, and we're not at liberty  
 6 to discuss the issue"?"  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. So why say anything?  
 11 MS. PREDHAM:  
 12 A. It wasn't my decision.  
 13 CHAYTOR, Q.C.:  
 14 Q. And did you have concerns that if we are going  
 15 to go out there and say anything that we not  
 16 give part of the information?  
 17 MS. PREDHAM:  
 18 A. I didn't have--I didn't want to go out and say  
 19 anything. So I mean, you know, that was -  
 20 CHAYTOR, Q.C.:  
 21 Q. But was there a greater concern with--you've  
 22 made the decision to go out and speak, so -  
 23 MS. PREDHAM:  
 24 A. I didn't make that decision.  
 25 CHAYTOR, Q.C.:

Page 170

1 Q. Yes, but there's a decision made within  
 2 Eastern Health, they're going to now go do  
 3 that. Your preference, you're saying, would  
 4 have been not to say anything. The decision  
 5 is made to go speak. So was there any concern  
 6 on your part "well, if you're going to do  
 7 that, make sure what we say is accurate"?"  
 8 MS. PREDHAM:  
 9 A. My biggest concern was that they not go out  
 10 with that calculation or make a calculation  
 11 based on those numbers.  
 12 CHAYTOR, Q.C.:  
 13 Q. And were you also concerned that they not go  
 14 out and give all the numbers?  
 15 MS. PREDHAM:  
 16 A. I can't remember being overly--yeah, I can't  
 17 remember that concern, and I've expressed my  
 18 concern about calculating an error rate based  
 19 on those numbers from a clinical perspective.  
 20 CHAYTOR, Q.C.:  
 21 Q. And if you go out with the 117 number, are you  
 22 aware that they also went out with the 2700,  
 23 approximate 2700 number of the total tests?  
 24 MS. PREDHAM:  
 25 A. I can't remember, but I think they did. I

Page 171

1 don't know.  
 2 CHAYTOR, Q.C.:  
 3 Q. Yes, and were you aware that that was part of  
 4 the plan, the 117, the 2700, and the 939 that  
 5 were retested?  
 6 MS. PREDHAM:  
 7 A. I may have known at the time. I can't  
 8 remember now.  
 9 CHAYTOR, Q.C.:  
 10 Q. And to go out and give those numbers, did you  
 11 have any concern or did anyone who was  
 12 discussing this have any concern "well, if we  
 13 go out with those three numbers, perhaps that  
 14 could be misconstrued and people could do  
 15 calculations on error rates"?"  
 16 MS. PREDHAM:  
 17 A. The only number I remember going out is the  
 18 117.  
 19 CHAYTOR, Q.C.:  
 20 Q. Were you present at the briefings?  
 21 MS. PREDHAM:  
 22 A. I did. I wasn't supposed to be, but I asked  
 23 if I could attend.  
 24 CHAYTOR, Q.C.:  
 25 Q. And you reviewed the Q and A's?

Page 172

1 MS. PREDHAM:  
 2 A. I don't think I had them until just before the  
 3 briefing.  
 4 CHAYTOR, Q.C.:  
 5 Q. Yes, and the press release?  
 6 MS. PREDHAM:  
 7 A. Again, I don't think I got any of that until  
 8 just before, the final copies.  
 9 CHAYTOR, Q.C.:  
 10 Q. So you did have it?  
 11 MS. PREDHAM:  
 12 A. Just before we went in.  
 13 CHAYTOR, Q.C.:  
 14 Q. Whatever documentation there was, you were  
 15 provided with it?  
 16 MS. PREDHAM:  
 17 A. I believe so.  
 18 CHAYTOR, Q.C.:  
 19 Q. And that documentation would show those three  
 20 numbers, correct?  
 21 MS. PREDHAM:  
 22 A. Oh, I can't remember.  
 23 CHAYTOR, Q.C.:  
 24 Q. Yes. So whatever documentation was in that,  
 25 whatever numbers was in that documentation,

Page 173

1 you had that documentation and those three  
 2 numbers, there was no concern that people  
 3 might take those numbers, those are the  
 4 numbers we're releasing publicly, and do their  
 5 own calculations and that would be of concern,  
 6 wouldn't it, to you that "well now they've  
 7 only taken part of the information and done  
 8 calculations"?

9 MS. PREDHAM:  
 10 A. It was not a concern at the time. I do know  
 11 that there was very clearly communicated that  
 12 we had not given them all the information.

13 CHAYTOR, Q.C.:  
 14 Q. And how was that clearly--you do recall that  
 15 being at the briefing and hearing that?

16 MS. PREDHAM:  
 17 A. Yes.

18 CHAYTOR, Q.C.:  
 19 Q. And how was that clearly communicated? By  
 20 whom?

21 MS. PREDHAM:  
 22 A. I think by Ms. Bonnell and I think by Dr.  
 23 Howell and I know at the first one, the CBC  
 24 one, I did--they were pressing a lot for this  
 25 and I just introduced myself and I said "I

Page 174

1 just want to remind you that we have an action  
 2 before the Court and we can't tell you  
 3 everything."

4 CHAYTOR, Q.C.:  
 5 Q. Okay. So at the--you were at the CBC one and  
 6 you were also at the second one for the  
 7 greater medium?

8 MS. PREDHAM:  
 9 A. Yes.

10 CHAYTOR, Q.C.:  
 11 Q. And what was it that the reporters were asking  
 12 for?

13 MS. PREDHAM:  
 14 A. If I recall, it was either, you know, how many  
 15 were wrong or how--you know, it was that type  
 16 of question, how many tests were wrong.

17 CHAYTOR, Q.C.:  
 18 Q. Did they ask how many overall had changed  
 19 results?

20 MS. PREDHAM:  
 21 A. I don't recall that.

22 CHAYTOR, Q.C.:  
 23 Q. Okay, and in hearing them ask "how many of  
 24 your tests were wrong?" what did you  
 25 understand them to be asking you?

Page 175

1 MS. PREDHAM:  
 2 A. Well, how many tests changed.

3 CHAYTOR, Q.C.:  
 4 Q. Yes, how many tests changed. So you heard  
 5 them ask that?

6 MS. PREDHAM:  
 7 A. Yes.

8 CHAYTOR, Q.C.:  
 9 Q. And was that question asked repeatedly?

10 MS. PREDHAM:  
 11 A. I do believe.

12 CHAYTOR, Q.C.:  
 13 Q. To the point where you spoke up?

14 MS. PREDHAM:  
 15 A. I did speak up at some point, and it was in  
 16 reference, just to remind them that there was  
 17 a law suit pending and usually we don't speak  
 18 before to the media.

19 CHAYTOR, Q.C.:  
 20 Q. And that there was certain information that  
 21 you couldn't give them?

22 MS. PREDHAM:  
 23 A. Yes.

24 CHAYTOR, Q.C.:  
 25 Q. And what information is it that you couldn't

Page 176

1 give them because it's before the courts?

2 MS. PREDHAM:  
 3 A. It was just a statement to say that we weren't  
 4 giving them all the information. It was just  
 5 to make that clear that we weren't giving them  
 6 all the information.

7 CHAYTOR, Q.C.:  
 8 Q. But what information is it, did you understand  
 9 you couldn't give them because it's before the  
 10 courts?

11 MS. PREDHAM:  
 12 A. Well, we agreed on what information we were  
 13 giving them, and I guess everything else was  
 14 what we weren't giving them.

15 CHAYTOR, Q.C.:  
 16 Q. So why was it okay to give the 117 and not  
 17 okay to give the 317?

18 MS. PREDHAM:  
 19 A. I wasn't part of that decision.

20 CHAYTOR, Q.C.:  
 21 Q. Okay, but you're a part of articulating the  
 22 position that "we can't give you all the  
 23 information because it's before the courts."

24 MS. PREDHAM:  
 25 A. Yes.

Page 177

1 CHAYTOR, Q.C.:

2 Q. So why can't you give them the 317?

3 MS. PREDHAM:

4 A. Like I said, the agreed upon plan when they

5 went in was to give them the 117.

6 CHAYTOR, Q.C.:

7 Q. Yes. So why can't you give them the 317?

8 MS. PREDHAM:

9 A. Because that was--it was agreed that it was

10 going to be the 117.

11 CHAYTOR, Q.C.:

12 Q. Because the matter is before the courts?

13 MS. PREDHAM:

14 A. Well, like I said before, I didn't want to

15 give them any information because it was

16 before the courts, but you know, it was

17 decided before we went in that we were going

18 to give them the 117 and that my memory was

19 that no other numbers were given, but--and

20 that was it.

21 CHAYTOR, Q.C.:

22 Q. And what else weren't--what other information

23 weren't you giving them because it's before

24 the courts?

25 MS. PREDHAM:

Page 178

1 A. I don't think that they were going into the

2 causes of it and getting into that discussion.

3 CHAYTOR, Q.C.:

4 Q. Okay, and that's reflected here in Ms.

5 Bonnell's e-mail as well. She says "however,

6 because of the law suit, we are limited in

7 what we can talk about in terms of causative

8 factors."

9 MS. PREDHAM:

10 A. And the individual information, they wouldn't

11 talk about any -

12 CHAYTOR, Q.C.:

13 Q. People's personal information, yes.

14 MS. PREDHAM:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. The causative factors then were not to be

18 spoken of because the matter was before the

19 courts?

20 MS. PREDHAM:

21 A. Yes.

22 CHAYTOR, Q.C.:

23 Q. And did you understand that to include

24 anything that you had determined from your

25 review or seen or observed from your review of

Page 179

1 the lab, as well as anything that Dr. Banerjee

2 or Ms. Wegrynowski would have been able to

3 determine?

4 MS. PREDHAM:

5 A. Yes.

6 CHAYTOR, Q.C.:

7 Q. And so in terms of what may have happened,

8 nothing, nothing should be said?

9 MS. PREDHAM:

10 A. That was my belief.

11 CHAYTOR, Q.C.:

12 Q. And that was the decision shared by all in

13 attendance and all who--so that was everybody

14 in attendance, participating in the media

15 briefings agreed with that view?

16 MS. PREDHAM:

17 A. Yes.

18 CHAYTOR, Q.C.:

19 Q. Okay, and did that question get asked? Were

20 they--did reporters ask one way or another

21 what happened?

22 MS. PREDHAM:

23 A. I can't remember. I really can't remember if

24 they asked that or not.

25 CHAYTOR, Q.C.:

Page 180

1 Q. And what went wrong, you don't recall if they

2 asked that?

3 MS. PREDHAM:

4 A. No.

5 CHAYTOR, Q.C.:

6 Q. And Ms. Bonnell refers to a meeting with Dan.

7 I take it that's Dan Boone?

8 MS. PREDHAM:

9 A. Yes.

10 CHAYTOR, Q.C.:

11 Q. And are you saying you don't recall attending

12 a meeting with Mr. Boone in which the issue of

13 what could be discussed at the media technical

14 briefings or otherwise disclosed publicly

15 could be--was discussed?

16 MS. PREDHAM:

17 A. No, I don't remember.

18 CHAYTOR, Q.C.:

19 Q. And did you yourself have discussions with him

20 around that?

21 MS. PREDHAM:

22 A. The only discussion I had with him was, I

23 guess, a little bit earlier. He didn't -

24 MR. SIMMONS:

25 Q. Excuse me. If I could just interrupt, just

Page 181

1 for a moment. I don't think there's any  
 2 problem with disclosing whether there were  
 3 discussions or not, but I note that with other  
 4 witnesses, such as Ms. Bonnell, there's been  
 5 care taken not to infringe on whether there  
 6 was any advice given around this particular  
 7 time, and not to stray into solicitor-client  
 8 privilege here. So there's no problem  
 9 identifying if there were discussions -  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes, I think other witnesses have spoken to  
 12 that though, what their recollections are  
 13 around that.  
 14 MR. SIMMONS:  
 15 Q. Yes, but when it's coming to--just as a  
 16 caution, if it's come to asking whether there  
 17 was any advice given and what the content of  
 18 that advice has been, I think that's been  
 19 respected so far and should continue to be  
 20 respected here. But the general nature of  
 21 whether there were any contacts perhaps what,  
 22 even general areas addressed.  
 23 THE COMMISSIONER:  
 24 Q. Well, let's find out what the specifics of  
 25 this are first. What's--where are we going

Page 182

1 with this to determine whether or not there's  
 2 any danger of straying into solicitor-client  
 3 privilege.  
 4 CHAYTOR, Q.C.:  
 5 Q. Sure, and perhaps my memory on that wasn't as  
 6 clear. I thought there had been discussion by  
 7 other witnesses on that issue as to what was  
 8 discussed in the meeting with Mr. Boone.  
 9 Perhaps I'll ask it this way then. Do you  
 10 know whether or not the decision that was made  
 11 as to what could be disclosed was in keeping  
 12 with the legal advice provided?  
 13 MS. PREDHAM:  
 14 A. I don't think we got any legal advice on that.  
 15 The only discussion was--and I don't know -  
 16 CHAYTOR, Q.C.:  
 17 Q. I don't know if it's something that -  
 18 MS. PREDHAM:  
 19 A. I don't know if I can say.  
 20 CHAYTOR, Q.C.:  
 21 Q. If it is something that you discussed then -  
 22 THE COMMISSIONER:  
 23 Q. If there's something you're uncertain about,  
 24 then let's not go down that road, at least  
 25 until we determine whether or not it might

Page 183

1 stray into solicitor-client privilege. But  
 2 what you're saying is that you don't think you  
 3 got legal advice on it?  
 4 MS. PREDHAM:  
 5 A. Exactly.  
 6 CHAYTOR, Q.C.:  
 7 Q. And so are you saying you didn't discuss with  
 8 Mr. Boone his views on what could be disclosed  
 9 publicly?  
 10 MS. PREDHAM:  
 11 A. I didn't.  
 12 CHAYTOR, Q.C.:  
 13 Q. And you're not aware that others did?  
 14 MS. PREDHAM:  
 15 A. Not that I know of. I don't know if they did  
 16 or not, but I didn't.  
 17 CHAYTOR, Q.C.:  
 18 Q. Do you think there was a meeting with him that  
 19 you didn't attend?  
 20 MS. PREDHAM:  
 21 A. Could have been, but I didn't--you know, I  
 22 certainly didn't have that discussion with  
 23 him. The discussion I had with him was about  
 24 one issue and it's not that.  
 25 CHAYTOR, Q.C.:

Page 184

1 Q. Okay, and your perspective though on this, in  
 2 terms of any reluctance to give out  
 3 information of the causative factors or  
 4 overall numbers, your reluctance was based on  
 5 your historical position to not discuss  
 6 matters that were before the Courts?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. What else do you recall happening at the  
 11 technical briefings? How did it go?  
 12 MS. PREDHAM:  
 13 A. The first one was a little bit--I can't think  
 14 of another word, it's not antagonistic, but it  
 15 was a little bit, you know, more aggressive, I  
 16 guess, in their questioning. But you know,  
 17 they went through the--Dr. Denic and Dr. Laing  
 18 went through their presentation. Dr. Howell  
 19 introduced it. Dr. Denic and Dr. Laing went  
 20 through their presentation and then they took  
 21 questions.  
 22 CHAYTOR, Q.C.:  
 23 Q. And what did you think was going to happen  
 24 afterwards, in terms of you finish your media  
 25 technical briefings. Did you think the media

Page 185

1 was satisfied that they had this information  
 2 and that the issue then would not arise again,  
 3 in terms of the points that couldn't be spoken  
 4 to?  
 5 MS. PREDHAM:  
 6 A. Oh no, I mean, as soon as things came forward  
 7 in court, as it progressed, then it would be,  
 8 you know, then it would be talked about.  
 9 CHAYTOR, Q.C.:  
 10 Q. Once the information is released in court?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And were you aware at that time that there was  
 15 an affidavit to come forward which you  
 16 ultimately became the person to sign in  
 17 February '07, and there's some reference that  
 18 that affidavit was originally supposed to be  
 19 filed December 15th, 2006. Were you aware  
 20 that that was in the works at the time, that  
 21 affidavit?  
 22 MS. PREDHAM:  
 23 A. No, I think I found out that somebody was  
 24 asking if it got filed or not, but that was in  
 25 January, and I certainly found out about the

Page 186

1 affidavit, but that was towards the end of  
 2 January, beginning of February.  
 3 CHAYTOR, Q.C.:  
 4 Q. The reference to ten percent, in the past  
 5 there had been reference to ten percent. In  
 6 some answers that you helped prepare and draft  
 7 to the MUSE, there was reference to this eight  
 8 to ten percent of patients may--who are being  
 9 retested may have a change. Did that come up,  
 10 the idea that we've already been out there in  
 11 the past talking about a ten percent or  
 12 thereabout change rate?  
 13 MS. PREDHAM:  
 14 A. That was only anticipated.  
 15 CHAYTOR, Q.C.:  
 16 Q. Yes.  
 17 MS. PREDHAM:  
 18 A. Because we had no results then, so that was  
 19 only what we would anticipate seeing.  
 20 CHAYTOR, Q.C.:  
 21 Q. Yes, but I'm just wondering, in the decisions  
 22 and the discussions leading up to the media  
 23 technical briefing, did that come up again?  
 24 Because you were conscious in the past of  
 25 being consistent in the messages that were

Page 187

1 going out with. So did it come up for  
 2 discussion again, "well, we've said ten  
 3 percent in the past. We can't give the  
 4 numbers now because obviously it's not that"?  
 5 MS. PREDHAM:  
 6 A. No, I don't recall anything like that.  
 7 CHAYTOR, Q.C.:  
 8 Q. Do you recall anyone referencing that ten  
 9 percent when you're trying to make up your  
 10 mind what can and cannot be disclosed?  
 11 MS. PREDHAM:  
 12 A. No, I don't recall that at all.  
 13 CHAYTOR, Q.C.:  
 14 Q. And who, in January 2006 (sic.), asked you if  
 15 the affidavit had been filed?  
 16 MS. PREDHAM:  
 17 A. I don't recall. I think there was an e-mail  
 18 that said apparently we missed some date or  
 19 something.  
 20 CHAYTOR, Q.C.:  
 21 Q. A deadline.  
 22 MS. PREDHAM:  
 23 A. A deadline, and somebody asked about it and I  
 24 had to check on it, and again, just that's a  
 25 vague memory.

Page 188

1 CHAYTOR, Q.C.:  
 2 Q. If I could have, please, 1207? And this  
 3 appears to be an e-mail about one of Dr.  
 4 Laing's patients that--it's January 25th '07.  
 5 "This lady called Nancy last week saying that  
 6 we had called her and told her that we were  
 7 going to retest her, but she had not heard  
 8 anything since. On checking into this, the  
 9 lady was retested and was shown to have a  
 10 changed ER/PR. She was panelled in February  
 11 2006, and a letter was written by Kara Laing  
 12 as chair of the panel to Kara, the most  
 13 responsible physician. After an incident with  
 14 another physician, the entire list," you go on  
 15 to say, "in September," sorry, "we contacted  
 16 all physicians who received a letter from the  
 17 panel to confirm that the patients had been  
 18 notified. This included all physicians at the  
 19 Cancer Clinic. After an incident with another  
 20 patient, the entire list was reviewed with the  
 21 leadership in the Cancer Care program. This  
 22 lady was on Dr. Laing's list."  
 23 So first of all, in September of 2006, it  
 24 says "we contacted all physicians who received  
 25 a letter from the panel to confirm that the

Page 189

1 patients had been notified." Is that correct?  
 2 MS. PREDHAM:  
 3 A. We attempt--well, we contacted them all, but  
 4 we didn't get many results back, and I guess  
 5 what my--the point I was trying to get across  
 6 is that we did contact the ones at the Cancer  
 7 Clinic and went through them and got feedback  
 8 from those.  
 9 CHAYTOR, Q.C.:  
 10 Q. So in September 2006, you had made attempts to  
 11 contact all the physicians?  
 12 MS. PREDHAM:  
 13 A. Well, we had contacted all the physicians  
 14 offices, but we didn't hear back from all of  
 15 them. But that wasn't--I guess I never went  
 16 into detail there because that wasn't the  
 17 point of what I was trying to say.  
 18 CHAYTOR, Q.C.:  
 19 Q. So why are you saying that at all, that--why  
 20 are you telling Oscar Howell, Pat Pilgrim, Pam  
 21 Elliott, Leona Barrington that in September  
 22 you contacted all physicians who received a  
 23 letter? Why is that being said in this  
 24 context at all?  
 25 MS. PREDHAM:

Page 190

1 A. I guess just in the preface to say that we did  
 2 hear back from the Cancer Care program, and  
 3 that they had contacted all these patients,  
 4 but this lady was on Dr. Laing's list.  
 5 CHAYTOR, Q.C.:  
 6 Q. And where is that written, that you heard back  
 7 from the Cancer Clinic physicians?  
 8 MS. PREDHAM:  
 9 A. It's not there.  
 10 CHAYTOR, Q.C.:  
 11 Q. Okay, and wouldn't this--anyone reading this,  
 12 be of--couldn't this easily be interpreted as  
 13 saying "well, we contacted all the physicians  
 14 to confirm the patients had been notified,"  
 15 that piece of work is done, without  
 16 qualification?  
 17 MS. PREDHAM:  
 18 A. Well, I guess it would be for someone who  
 19 wasn't the people that I'm sending it to,  
 20 because the people I'm sending it to would  
 21 have known the circumstances at the time and  
 22 the difficulties that we had.  
 23 CHAYTOR, Q.C.:  
 24 Q. And Dr. Howell would have known that?  
 25 MS. PREDHAM:

Page 191

1 A. Yes, because he was--he had started by then.  
 2 CHAYTOR, Q.C.:  
 3 Q. So Dr. Howell, you're saying, would have been  
 4 well aware that you had to abort your attempt  
 5 to get confirmation from all the physicians  
 6 that they had confirmed with their patients  
 7 and notified their patients?  
 8 MS. PREDHAM:  
 9 A. Well, we didn't abort it. We attempted it,  
 10 but we weren't successful in completing it.  
 11 We didn't--we couldn't get cooperation from  
 12 the physicians to get it finished.  
 13 CHAYTOR, Q.C.:  
 14 Q. Yes, and you couldn't make contact with all of  
 15 the physicians?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 THE COMMISSIONER:  
 19 Q. Couldn't make contact or they didn't get back  
 20 to you?  
 21 MS. PREDHAM:  
 22 A. I think we made contact with all the--and of  
 23 course, that was Ms. Parsons that was doing  
 24 that, but I was aware that we made contact  
 25 with all the physicians offices, but they

Page 192

1 didn't get back to us.  
 2 THE COMMISSIONER:  
 3 Q. Okay.  
 4 CHAYTOR, Q.C.:  
 5 Q. And Dr. Howell was aware of your difficulties  
 6 in that respect?  
 7 MS. PREDHAM:  
 8 A. Oh yes.  
 9 CHAYTOR, Q.C.:  
 10 Q. You indicate "unfortunately Kara was not now  
 11 available to meet with this lady and explain  
 12 why she was missed." Why was she missed?  
 13 MS. PREDHAM:  
 14 A. I'm not sure.  
 15 CHAYTOR, Q.C.:  
 16 Q. And did you carry out any investigation to  
 17 figure out how that could have happened?  
 18 MS. PREDHAM:  
 19 A. No, I did not.  
 20 CHAYTOR, Q.C.:  
 21 Q. And how could it be that this person was  
 22 panelled and almost a year later, February  
 23 '06, she's panelled and almost a year later  
 24 she doesn't know her results?  
 25 MS. PREDHAM:



Page 193

1 A. It's very unfortunate.  
 2 CHAYTOR, Q.C.:  
 3 Q. But there has been no inquiry to determine how  
 4 that could have happened?  
 5 MS. PREDHAM:  
 6 A. No. No inquiry by me, I should say.  
 7 CHAYTOR, Q.C.:  
 8 Q. And do you know whether or not anyone has  
 9 carried out an inquiry so that that could be  
 10 covered off?  
 11 MS. PREDHAM:  
 12 A. You'd have to ask Dr. Howell that, he would  
 13 have had to follow up with Dr. Laing.  
 14 CHAYTOR, Q.C.:  
 15 Q. If we could have, please, P-3058? It's an e-  
 16 mail of January 26th, 2007 and I've moved on  
 17 into 2007, but just before I do that, I just  
 18 want to make clear there were--the external  
 19 reviewers did come back, I didn't cover that  
 20 off with you in 2006, except probably in a  
 21 roundabout way. You were aware, of course,  
 22 they came back.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

Page 194

1 Q. Dr. Banerjee and Ms. Wegrynowski. Did you  
 2 receive copies of their reports in 2006, their  
 3 subsequent reports?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CHAYTOR, Q.C.:  
 7 Q. And we understand that was in the spring of  
 8 2006 and maybe around May of 2006, the reports  
 9 came back? Whenever they came back, I take it  
 10 you got a copy at the time.  
 11 MS. PREDHAM:  
 12 A. I did, yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And you're writing to Sharon Smith, "Here's  
 15 the latest" and the first e-mail is January  
 16 25th, the day before, you got off the phone  
 17 with, I take it it's Dr. Howell, is it?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. "He feels we have to assume that there is  
 22 another missed person out there and we need to  
 23 triple check the notifications. Here's the  
 24 tentative plan. I'll review the panel list  
 25 with Nancy and we can eliminate those we know

Page 195

1 for a fact to be contacted, i.e. the ones who  
 2 have come forwarded in the media and those  
 3 that have called us and complained, et cetera.  
 4 Were the Cancer Clinic charts and those seen  
 5 by Drs. Felix and Kwan, I'll review the charts  
 6 and ensure there is some documented evidence  
 7 of follow up. For the rest, I'll call the  
 8 patient to ensure that they have been  
 9 contacted. By the way, Dr. Howell was unaware  
 10 of this latest situation before the media  
 11 request." And what's this all about?  
 12 MS. PREDHAM:  
 13 A. Well this was in response to that latest one  
 14 that got missed, as Dr. Howell said, if  
 15 there's one out there, then there's going to  
 16 be more than one. And he wanted to go through  
 17 a systemic way of identifying if everyone had  
 18 been communicated with that had a panel  
 19 letter.  
 20 CHAYTOR, Q.C.:  
 21 Q. So by this point in time, were you--did you  
 22 share Dr. Howell's concern, well if there's  
 23 one missed, there likely are others?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 196

1 CHAYTOR, Q.C.:  
 2 Q. Did you have that concern anyhow before this?  
 3 MS. PREDHAM:  
 4 A. Well yes, I did all fall when we had those,  
 5 you could see I was concerned, so yes, I had  
 6 that concern.  
 7 CHAYTOR, Q.C.:  
 8 Q. And did you do the plan here and go through--  
 9 did you review the panel list with Nancy? Did  
 10 you review the Cancer Clinic charts and the  
 11 charts of Dr. Felix and Kwan?  
 12 MS. PREDHAM:  
 13 A. No, because I had a family emergency at that  
 14 time and I was not fully working.  
 15 CHAYTOR, Q.C.:  
 16 Q. And did anyone else undertake this work while  
 17 you weren't there?  
 18 MS. PREDHAM:  
 19 A. No, not at that time.  
 20 CHAYTOR, Q.C.:  
 21 Q. Was it ever undertaken?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And when was that?

Page 197

1 MS. PREDHAM:  
 2 A. That was this year, in May.  
 3 CHAYTOR, Q.C.:  
 4 Q. May of 2008?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 CHAYTOR, Q.C.:  
 8 Q. And why didn't anyone pick up and do it before  
 9 then?  
 10 MS. PREDHAM:  
 11 A. I'm not sure.  
 12 CHAYTOR, Q.C.:  
 13 Q. If we could have, please, P-3059? This looks  
 14 like it's another ATIPP request from Mr.  
 15 Quinn?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. And you're e-mailing to Marian Crowley. The  
 20 subject line is March 1st, 2005. Why would  
 21 that be?  
 22 MS. PREDHAM:  
 23 A. I don't know.  
 24 CHAYTOR, Q.C.:  
 25 Q. And it appears you're forwarding to her the

Page 198

1 letter from--or the letter that was sent to  
 2 Mr. Quinn.  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. Responding to his ATIPP request, "This is to  
 7 confirm that on February 15th, 2007, Eastern  
 8 Health received your request." So this is  
 9 just the confirmation letter that his request  
 10 has been received.  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And it's a draft letter intended for her  
 15 signature?  
 16 MS. PREDHAM:  
 17 A. Yes. Marian had taken over that position for  
 18 the ATIPP request and I guess at this point in  
 19 time, we realized that the templates and that  
 20 were still on my computer.  
 21 CHAYTOR, Q.C.:  
 22 Q. And were you then involved at all in this  
 23 response, this ATIPP response to Mr. Quinn?  
 24 MS. PREDHAM:  
 25 A. Only peripherally.

Page 199

1 CHAYTOR, Q.C.:  
 2 Q. In the same manner in which you are involved  
 3 in the 2006 request?  
 4 MS. PREDHAM:  
 5 A. Even less than that. I gave advice to Deanne  
 6 on searching computers and that at that time,  
 7 but this time Marian did this all herself.  
 8 CHAYTOR, Q.C.:  
 9 Q. And Mr. Quinn has referred to the affidavit  
 10 which was filed in February, 2007. Who made  
 11 that decision to refer Mr. Quinn to your  
 12 affidavit?  
 13 MS. PREDHAM:  
 14 A. In discussion, he was requesting all results  
 15 of that and I know in a discussion that we had  
 16 of, I guess the broader group involved in  
 17 ER/PR, we had a bit of a problem giving, even  
 18 if we de-identified lab results, de-identified  
 19 anything that was part of the patient record,  
 20 to release that and that was our discussion  
 21 that we were having and as I recall for some  
 22 reason, Susan and I were talking about it and  
 23 we were also, I think we were talking about  
 24 something else with one of the legal counsel  
 25 at Stewart McKelvey who suggested that and I

Page 200

1 guess we must have made some comment -  
 2 CHAYTOR, Q.C.:  
 3 Q. And you might not want to tell me that.  
 4 MS. PREDHAM:  
 5 A. Oh, well it was just to point them in the  
 6 direction of the affidavit.  
 7 CHAYTOR, Q.C.:  
 8 Q. Okay.  
 9 MS. PREDHAM:  
 10 A. And see if that met his--because part of the  
 11 ATIPP is that you have a duty to assist, so he  
 12 may be satisfied with the information that's  
 13 in the affidavit and may not need the full  
 14 detail of all the issues that we had a problem  
 15 with.  
 16 CHAYTOR, Q.C.:  
 17 Q. And was that satisfactory to Mr. Quinn?  
 18 MS. PREDHAM:  
 19 A. No, he went to the Privacy Commissioner.  
 20 CHAYTOR, Q.C.:  
 21 Q. And if we could look, please, at P-2116? And  
 22 this is a further e-mail from Marian Crowley  
 23 to Drs. Cook and Denic and then Dr. Cook to  
 24 Marian Crowley, April 3rd, "Hi Marian, in  
 25 speaking to Dr. Denic, I understand he was

Page 201

1 already talking to you today, as well as  
 2 speaking to Heather yesterday on this issue."  
 3 And it's regarding, it appears, ER/PR patient  
 4 reports. She says, "We had a request from a  
 5 reporter asking for the actual ER/PR test  
 6 results of the patients affected with the  
 7 local results and retest results from Mount  
 8 Sinai. We denied the release citing that the  
 9 results were personal information. The  
 10 reporter has appealed to the Privacy  
 11 Commissioner who has ordered the reports sent  
 12 to his office for review. We've been down  
 13 this road before. We are legally obligated to  
 14 send the results to the Privacy Commissioner's  
 15 office. We have to provide the reports by  
 16 next week. I've discussed this with Heather  
 17 and we need your advice about how these  
 18 reports can be generated as expeditiously as  
 19 possible." So I take it that that's just  
 20 showing that Mr. Quinn was persistent in  
 21 wanting the information.  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. This issue, of course, takes on a fairly high

Page 202

1 public profile again after Mr. Quinn's story  
 2 comes out on May 15th, 2007. Were you aware  
 3 beforehand that that was going to happen, that  
 4 Mr. Quinn was going to be writing a story?  
 5 MS. PREDHAM:  
 6 A. My only knowledge of it, I left the Health  
 7 Sciences and was just--I had a specialist  
 8 appointment and I was in the parking lot when  
 9 Ms. Bonnell paged me and she told me that Mr.  
 10 Quinn had the affidavit and he said that the  
 11 numbers didn't add up and my first response  
 12 was that, the math, the numbers do add up, I  
 13 was thinking math wise, you know, not, you  
 14 know, what he eventually took from that and I  
 15 told Ms. Bonnell I couldn't talk to her  
 16 because I was waiting for the specialist  
 17 appointment so long, I had to go in, and after  
 18 that, I went to, I believe it was Regional and  
 19 Quality Council. Dr. Howell was there and I  
 20 said, "you heard that Mark Quinn had called  
 21 about the affidavit." And Dr. Howell said,  
 22 "yes, and we're not commenting."  
 23 CHAYTOR, Q.C.:  
 24 Q. So Eastern Health's decision was going to be  
 25 not to say anything in response?

Page 203

1 MS. PREDHAM:  
 2 A. Yes.  
 3 CHAYTOR, Q.C.:  
 4 Q. And how did you--what was your opinion of  
 5 that? Did you have any issue with that or did  
 6 you think that was the right course of action?  
 7 MS. PREDHAM:  
 8 A. I was a bit surprised, but I wasn't part of  
 9 any discussion about it, then or after.  
 10 CHAYTOR, Q.C.:  
 11 Q. And if we could look at P-3060 please? And  
 12 May 16th, 2006, Ms. Crowley write yourself and  
 13 Ms. Elliott and copies to Mr. Boone that "The  
 14 Privacy Commissioner's office is moving ahead  
 15 with the formal review of Mark Quinn's request  
 16 for the ER/PR results of the patients. Mark  
 17 is not satisfied with the information in the  
 18 affidavit and he wants the patient reports."  
 19 So I take it there was something more that he  
 20 was looking for than what could be obtained in  
 21 the affidavit?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 CHAYTOR, Q.C.:  
 25 Q. And did you understand what it was, what was

Page 204

1 the detail that Mr Quinn was requesting?  
 2 MS. PREDHAM:  
 3 A. Well his request was for all original results  
 4 and all retested results and I do believe that  
 5 was the--that's my memory of what the request  
 6 was and he wasn't getting that information  
 7 from the affidavit.  
 8 CHAYTOR, Q.C.:  
 9 Q. At the time that the affidavit was filed in  
 10 Court in February, did you have any concerns  
 11 at that point in time in having all of the  
 12 numbers made public?  
 13 MS. PREDHAM:  
 14 A. No, because that was progressing through the  
 15 Court, that was--that was the--that was what I  
 16 expected.  
 17 CHAYTOR, Q.C.:  
 18 Q. And was there any discussion at that point in  
 19 time that, well this is the same information  
 20 that we weren't prepared to make public just a  
 21 couple of months ago?  
 22 MS. PREDHAM:  
 23 A. At that time, I didn't have any discussion  
 24 with anybody about that.  
 25 CHAYTOR, Q.C.:

Page 205

1 Q. And if we could have, please, P-0704? And  
 2 this is from Marian Crowley to a number of  
 3 people, including yourself and Louise Jones,  
 4 Pam Elliott, Rick Singleton and Pat Pilgrim  
 5 and it's July 6th, 2007. "Hi all, just to  
 6 clarify" -  
 7 MS. PREDHAM:  
 8 A. I think you need to read the -  
 9 CHAYTOR, Q.C.:  
 10 Q. Okay, read the first one?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. So it's an e-mail, it originates from Rick  
 15 Singleton to Louise Jones, July 5th. "Hi  
 16 Louise, while I think that last Friday at the  
 17 Steering Committee on confidentiality, Marian  
 18 Crowley happened to mention that the Privacy  
 19 Commissioner's recommended release of health  
 20 records, names blocked of patients involved in  
 21 ER/PR. She then went on to mention that she  
 22 consulted Richard Newman of HIC of the Ethics  
 23 of such a release. He advised that he saw no  
 24 problem with it and made the analogy to an  
 25 unanimous chart reviews as part of research.

Page 206

1 A few concerns came to my mind, why would she  
 2 consult on the ethics outside our own  
 3 structure? Why would she consult with someone  
 4 who is not an ethicist and the comparison of  
 5 CBC chart access and researchers is somewhat  
 6 deficient." What--were you present when Mr.  
 7 Crowley had made this inquiry of Mr. Newman?  
 8 MS. PREDHAM:  
 9 A. Yes. And I think she referenced that at that  
 10 top e-mail.  
 11 CHAYTOR, Q.C.:  
 12 Q. Yes, and what do you recall about that? What  
 13 was that all about?  
 14 MS. PREDHAM:  
 15 A. Well we were at a privacy conference,  
 16 actually, and we were talking about this ATIPP  
 17 request, it was shortly after the request came  
 18 in and both of us had a problem, although  
 19 there was no, I guess, you know, you go for  
 20 years working under the Hospitals Act and you  
 21 had very limited access, external access to a  
 22 person's health record and now we have this  
 23 ATIPP legislation and there wasn't any clear  
 24 cut that would prevent anybody from asking  
 25 for, for a group of people, information that's

Page 207

1 on a patient's chart and it just didn't seem  
 2 right. And we were discussing this and we  
 3 happened to come across Dr. Newman at this  
 4 conference or workshop and we just said like,  
 5 from a research perspective, it wasn't an  
 6 ethics consultation at all, it was from--from  
 7 a research perspective, if this request had  
 8 come into HIC, would you require consent or  
 9 what would you require? And he told us that  
 10 he didn't--we couldn't use that as a reason to  
 11 refuse disclosure, he didn't feel there was  
 12 anything--he didn't think there was anything  
 13 stopping us from releasing it.  
 14 CHAYTOR, Q.C.:  
 15 Q. And then the next day, July 6th, 2007, Ms.  
 16 Crowley writes, "Just to clarify, at the time  
 17 that we were preparing to respond to the ATIPP  
 18 request for release of the ER/PR patients'  
 19 results, Heather and I were discussing all of  
 20 the possible exceptions to disclosure of such  
 21 information. One of the scenarios we  
 22 discussed was whether the info requested could  
 23 be classified as health research where we knew  
 24 there would be rigorous HIC expectations. We  
 25 ran into Richard Newman at the workshop and

Page 208

1 had a chat with him about it because there was  
 2 no hypotheses, et cetera, Richard felt we  
 3 couldn't use that reason to refuse disclosure.  
 4 We were not looking at this as an ethics  
 5 consultation. I have personally been involved  
 6 in several ethical consults with Rick's great  
 7 team, but when it comes to access to  
 8 information legislation, ethics is  
 9 unfortunately not one of the exceptions in the  
 10 legislation." And so, I'm just trying to  
 11 think, so the idea of trying to refuse the  
 12 disclosure to Mr. Quinn as somehow being  
 13 classified as health research?  
 14 MS. PREDHAM:  
 15 A. Well, I mean, it wasn't--it wasn't looking as  
 16 a reason to refuse it, it just didn't seem  
 17 right. If you were going to do research  
 18 tomorrow on ER/PR or anything, you would have  
 19 to do a proposal to HIC. HIC would have to  
 20 review it and come up with whether or not  
 21 you'd need consent or anything and just go  
 22 through that process. But here we were faced  
 23 with someone with an ATIPP request looking for  
 24 information and it didn't seem to have any of  
 25 that scrutiny level on it. So it was just a

Page 209

1 disconnect.

2 CHAYTOR, Q.C.:

3 Q. But did you ever think that the ER/PR review

4 was ever health research?

5 MS. PREDHAM:

6 A. No, no, no, it was just the ability for

7 someone off the street to access information

8 from a patient's chart. It was just--we

9 hadn't thought about it before. It was

10 irrelevant of ER/PR, what our thinking was.

11 It could have been anything that somebody

12 would have called. If anybody wanted to know

13 the blood sugar results of all men from age 40

14 to 50 that were conducted within the past

15 month at the Health Sciences Centre, I don't

16 know, it just seems like an odd thing that you

17 would give out from an ATIPP request.

18 CHAYTOR, Q.C.:

19 Q. If we could have, please, P-3064?

20 THE COMMISSIONER:

21 Q. Ms. Chaytor, we'll take our luncheon break

22 when you're ready.

23 CHAYTOR, Q.C.:

24 Q. And this is an e-mail between yourself and Ms.

25 Parsons and she's advising--take you to the

Page 210

1 bottom here. It's from a patient, "I have

2 been a patient at the Cancer Centre, I'm in

3 the group that had ER/PR testing in 1999. My

4 testing came back negative and I did not

5 receive Tamoxifen. I've never been informed

6 if my test results changed. Certainly there

7 will be some effort to contact women in my

8 situation or are we all expected to call into

9 our oncologists separately." And this is May

10 15th, 2007. Nancy says, "Thank you for

11 contacting us." And she then lets you know

12 and you say "Thank you, Nancy, for your prompt

13 attention. I appreciate getting the result

14 today on my voice mail. I think patients

15 would appreciate a letter in the mail about

16 the testing and your numbers so we can get

17 their test results." So I take it then at

18 this point in time, you're keenly aware that

19 not all patients had been contacted?

20 MS. PREDHAM:

21 A. Oh yes.

22 CHAYTOR, Q.C.:

23 Q. And not only would you be hearing that in the

24 middle of May--in the media, you in fact are

25 receiving communication directly from patients

Page 211

1 to that effect?

2 MS. PREDHAM:

3 A. Yes.

4 CHAYTOR, Q.C.:

5 Q. Did you provide assurances to anyone in May of

6 2007 that all patients had in fact been

7 contacted?

8 MS. PREDHAM:

9 A. I don't recall doing that.

10 CHAYTOR, Q.C.:

11 Q. And would you have done that in light of this?

12 MS. PREDHAM:

13 A. No, I can't--like I said, for anything with

14 ER/PR, I never said anything was a black and

15 white done issue.

16 CHAYTOR, Q.C.:

17 Q. Thank you, Commissioner.

18 THE COMMISSIONER:

19 Q. We'll meet at 2:25.

20 (ADJOURNED FOR LUNCH)

21 THE COMMISSIONER:

22 Q. Please be seated. Ms. Chaytor.

23 CHAYTOR, Q.C.:

24 Q. Good afternoon. If I could have, please, P-

25 0106? And this is an e-mail of May 16th, 2007

Page 212

1 to Mr. Tilley, Dr. Howell and Ms. Bonnell from

2 yourself. And it's re: "ER/PR testing media

3 coverage. Hi all, there's part of me that

4 totally agrees and feels that we should be out

5 on roof tops clarifying this point"--and I'll

6 take you down here, it's an opinion of board

7 member Bill Boyd, who is a lawyer. And he has

8 some concerns, he says, "Thanks for the heads

9 up, George. I was confronted today with the

10 story and questions from colleagues. I heard

11 the comments from the Minister during the

12 supper hour. He must say more than Eastern

13 Health was advised by lawyers to not disclose

14 information, that sounds very bad and makes it

15 appear that we deliberately misled. We must

16 respond, in my view, to the allegations that

17 we misled the media and the public in our

18 previous disclosures, I think we can do so

19 without prejudicing the legal case for the

20 defence." And you will see that it originated

21 from Mr. Tilley sending an e-mail to the Board

22 of Trustee members explaining how the 117 was

23 released and then the 317 being referenced in

24 the affidavit. And your response is, "There's

25 part of me that totally agrees and feels that

Page 213

1 we should be out on the roof tops clarifying  
 2 this point. I admit I only heard part of the  
 3 coverage. I had to turn off Lorraine Michaels  
 4 and I couldn't bear to watch Peter Dawe on  
 5 "Out of the Fog". The other part of me is  
 6 thinking we're only going to give them more  
 7 fodder and that whatever we say will fan the  
 8 fires and it would be better to hold the "no  
 9 comment" line. I'll call Dan this a.m. I got  
 10 a voice mail from his last night. He was at a  
 11 pre-hearing meeting with the judge re: the  
 12 certification and the judge believes that  
 13 Ches's case is not developed enough to be  
 14 heard and wants to postpone it until  
 15 September. The difficult part of the message  
 16 to hear is that I think Dan said that Ches  
 17 still wants to proceed. I guess the key point  
 18 of clarification is that all the patients who  
 19 need to know knows. It's the general public  
 20 and the media that doesn't have the details  
 21 and that is because it's before the Courts."  
 22 And first of all, what was your issue, Ms.  
 23 Predham, with trying to watch the media  
 24 coverage with Ms. Lorraine Michaels and Mr.  
 25 Peter Dawe?

Page 214

1 MS. PREDHAM:  
 2 A. Well I'm glad you asked me about that e-mail,  
 3 it was certainly not anything to do with Ms.  
 4 Michaels or Mr. Dawe, it was just the fact  
 5 that the media--it was just the media coverage  
 6 and I just reference the two of those, that it  
 7 was--I guess it was gone off in a total  
 8 direction in which I didn't expect and I  
 9 couldn't believe had occurred and I just found  
 10 it difficult to listen to.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay, so why is that at this point in time,  
 13 how is it you couldn't believe it had taken  
 14 the turn of events or the direction that it  
 15 had gone at this point?  
 16 MS. PREDHAM:  
 17 A. I think the media was saying that we were  
 18 covering up and, you know, those types of  
 19 issues and I guess it was just--it just seemed  
 20 to be spiralling at that time. But it was  
 21 certainly nothing about Ms. Michaels or Mr.  
 22 Dawe at all, I just happened to be listening  
 23 to them, they were being interviewed and I  
 24 just, you know, I had to turn it off. It was  
 25 just the way the story was unfolding, nothing

Page 215

1 to do with them personally.  
 2 CHAYTOR, Q.C.:  
 3 Q. And what was it about the story, how it was  
 4 unfolding that was so disturbing to you?  
 5 MS. PREDHAM:  
 6 A. Well it was the fact that we were covering up  
 7 or we were trying to hide things or that we  
 8 had tried to mislead people, that part of the  
 9 story.  
 10 CHAYTOR, Q.C.:  
 11 Q. And the other part of me, you're saying is  
 12 thinking "we're only going to give them more  
 13 fodder in whatever we say will fan the fires."  
 14 Give more fodder to who?  
 15 MS. PREDHAM:  
 16 A. I guess and again, this was a--this is one of  
 17 those e-mails that, you know, if I had waited  
 18 ten more minutes, I probably wouldn't have  
 19 sent and I wouldn't have sent it like it was.  
 20 It was just--I just reacted and I was probably  
 21 just, again, a little bit too sensitive at the  
 22 moment and should have went and got a cup of  
 23 coffee before I sent the e-mail, but really I  
 24 was only thinking that the media were aware at  
 25 the time in December that we weren't telling

Page 216

1 them all the information, but now it looks  
 2 like they felt that we were hiding things.  
 3 But they were aware back in December that we  
 4 didn't tell them everything.  
 5 CHAYTOR, Q.C.:  
 6 Q. Even though they were asking the questions or  
 7 certain questions repeatedly looking for the  
 8 information.  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. So how did you think it would unfold when they  
 13 did receive all the information? Did you  
 14 expect that the reaction would be any  
 15 different than what it in fact was?  
 16 MS. PREDHAM:  
 17 A. I really, with that spring and everything that  
 18 was going on with me, I really hadn't put too  
 19 much thought into it of how that would unfold.  
 20 CHAYTOR, Q.C.:  
 21 Q. Yes, so by this point in time you are  
 22 surprised, you can't believe how the turn of  
 23 direction and what's happened.  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 217

1 CHAYTOR, Q.C.:

2 Q. So I guess you weren't, you couldn't

3 understand how they could even think that they

4 had been misled?

5 MS. PREDHAM:

6 A. I was surprised, I, you know, it was very

7 clear to me in December and I guess that's

8 what I was thinking, it was very clear in

9 December that they knew they didn't have all

10 the information, yet, you know, here it was,

11 it was like we were trying to mislead them

12 when, you know.

13 CHAYTOR, Q.C.:

14 Q. Was it because they were given partial

15 information which would have left a certain

16 impression and now that they had all the

17 information, they could see that it was a

18 different picture?

19 MS. PREDHAM:

20 A. Oh, well obviously that's what it was, but

21 like I said, I was reacting here. I was just

22 reacting that morning.

23 CHAYTOR, Q.C.:

24 Q. So once you had time to have that further cup

25 of coffee and reflect on it a little more, you

Page 218

1 could probably understand their point?

2 MS. PREDHAM:

3 A. Well probably in May 2007, it might have been,

4 you know, a couple of days later, I might have

5 appreciated differently.

6 CHAYTOR, Q.C.:

7 Q. A few cups of coffee later.

8 MS. PREDHAM:

9 A. Yes, I would have appreciated their point.

10 CHAYTOR, Q.C.:

11 Q. Yes, okay. And so the them, in terms of who

12 you're going to give more fodder to, do you

13 mean the media?

14 MS. PREDHAM:

15 A. Yes.

16 CHAYTOR, Q.C.:

17 Q. And "whatever we say will fan the fires" and

18 so are you saying here that--you go on to say

19 it's better to hold the "no comment" line.

20 MS. PREDHAM:

21 A. No, I was totally torn, I wasn't adding

22 anything to the conversation because a part of

23 me said yes, tell them everything, and a part

24 of me was saying, you know, there wasn't any

25 point.

Page 219

1 CHAYTOR, Q.C.:

2 Q. And you phoned Mr. Boone and what would be

3 your purpose in phoning Mr. Boone at this

4 point?

5 MS. PREDHAM:

6 A. I don't know. It looks like I was giving an

7 update on the class action lawsuit.

8 CHAYTOR, Q.C.:

9 Q. And would you be seeking advice as to whether

10 or not you should go out and say anything

11 further at this point from Mr. Boone?

12 MS. PREDHAM:

13 A. No, it doesn't look like it, it looks like--

14 and I don't believe if--can you just scroll

15 down for a moment?

16 CHAYTOR, Q.C.:

17 Q. Sure.

18 MS. PREDHAM:

19 A. I don't believe I was asked to do that. I

20 wasn't asked to do anything.

21 CHAYTOR, Q.C.:

22 Q. You just forwarded it on--you weren't asked to

23 do anything.

24 MS. PREDHAM:

25 A. Yeah.

Page 220

1 CHAYTOR, Q.C.:

2 Q. Now who wrote this, "H. Predham, question what

3 this means"?

4 MS. PREDHAM:

5 A. No.

6 CHAYTOR, Q.C.:

7 Q. And you're not asked to do anything in

8 particular, so do you know the purpose whether

9 or not you were seeking advice from Mr. Boone

10 as to whether or not Eastern Health should be

11 out saying anything further in the middle of

12 May, 2007?

13 MS. PREDHAM:

14 A. No, I think the only reason I was calling him

15 is because he sent me, he left me a voice mail

16 which was very hard to understand and I was

17 going to clarify that.

18 CHAYTOR, Q.C.:

19 Q. You finish this e-mail by saying, "I guess the

20 key point of clarification is that all the

21 patients who need to know, knows. It's the

22 general public and the media that doesn't have

23 all the details and that is because it's

24 before the Court." Ms. Predham, could you say

25 with any certainty that all the patients who

Page 221

1 need to know, knew at that point?  
 2 MS. PREDHAM:  
 3 A. Oh no, and at this point, you know, I don't  
 4 believe anybody would go off based on this e-  
 5 mail, I guess the point I was trying to get  
 6 across was that the patients were communicated  
 7 with and yes, we knew there were patients that  
 8 didn't get communicated with, but the bulk of  
 9 them had been communicated with. But it was  
 10 the media that didn't have all the details.  
 11 CHAYTOR, Q.C.:  
 12 Q. But is that what this says? This is not--this  
 13 is saying "The key point of clarification"--so  
 14 the key point of clarification, are you  
 15 advocating going out and saying that, making a  
 16 public statement that all patients who need to  
 17 know, know?  
 18 MS. PREDHAM:  
 19 A. Well I wouldn't say that, like I said, this  
 20 was a very quick response and what the point  
 21 is is that we weren't hiding results from  
 22 patients.  
 23 CHAYTOR, Q.C.:  
 24 Q. Now, Ms. Predham, by saying this or writing  
 25 this to Mr. Tilley on May 16th, 2007, aren't

Page 222

1 you telling him that all the patients who need  
 2 to know knows? You're not saying, Mr. Tilley,  
 3 the bulk of patients know, there may be some  
 4 that we're hearing from, including the patient  
 5 that contacted us yesterday, you're saying  
 6 that, telling Mr. Tilley in writing in this e-  
 7 mail that all the patients who need to know,  
 8 know.  
 9 MS. PREDHAM:  
 10 A. Ms. Chaytor, I would never expect that a CEO  
 11 or a VP of Medical Services would take a  
 12 comment in an e-mail such as that as a fact  
 13 and move forward with it.  
 14 CHAYTOR, Q.C.:  
 15 Q. Who was the person responsible within Eastern  
 16 Health for patient contact?  
 17 MS. PREDHAM:  
 18 A. Myself.  
 19 CHAYTOR, Q.C.:  
 20 Q. So if Mr. Tilley is hearing this as a key  
 21 point of clarification from the person  
 22 responsible for patient contact, that all the  
 23 patients who need to know knows, you wouldn't  
 24 expect him to rely upon that?  
 25 MS. PREDHAM:

Page 223

1 A. Not when everything I said before that was  
 2 that we were having difficulties with  
 3 communication. If--if he had read that and  
 4 was going forward with that fact, he would  
 5 have to say what has happened, you know,  
 6 since--to make sure that everybody know.  
 7 CHAYTOR, Q.C.:  
 8 Q. And when is the last time prior to May 16th,  
 9 2007, you had any communication with Mr.  
 10 Tilley as to the status of patient contact?  
 11 MS. PREDHAM:  
 12 A. I'm not sure, but if anybody asked me about  
 13 patient contact, I never ever said that  
 14 everybody knew.  
 15 CHAYTOR, Q.C.:  
 16 Q. Except in this e-mail?  
 17 MS. PREDHAM:  
 18 A. Except in this e-mail, which I admit I did  
 19 quickly, and should have taken time to write  
 20 it out properly.  
 21 CHAYTOR, Q.C.:  
 22 Q. And this is at a point in time where whether  
 23 all the patients know is a fairly hot topic?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 224

1 CHAYTOR, Q.C.:  
 2 Q. If we could have, please, P-3065. This is an  
 3 e-mail, May 18th, to Susan Bonnell, "As  
 4 promised, I'll be there in about five  
 5 minutes", and you've attached the  
 6 interrogatory questions document and affidavit  
 7 document, and you'll see your affidavit is  
 8 attached here, as well as the answers to  
 9 interrogatories. I believe you did two  
 10 answers to interrogatories.  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. And this is the answers to the March 30th,  
 15 2007. Why are you forwarding this on to Ms.  
 16 Bonnell on May 18th, 2007?  
 17 MS. PREDHAM:  
 18 A. I don't remember, but I would assume that she  
 19 would like to know any documents that are in  
 20 the court that are public documents.  
 21 CHAYTOR, Q.C.:  
 22 Q. And you were headed out to a meeting with her,  
 23 you were going to be there in fifteen minutes,  
 24 I think the e-mail said?  
 25 MS. PREDHAM:



Page 225

1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. So was there a meeting then of a group of  
 4 people on May 18th?  
 5 MS. PREDHAM:  
 6 A. I don't recall, but there were several  
 7 meetings at the time, but I don't recall, in  
 8 particular.  
 9 CHAYTOR, Q.C.:  
 10 Q. And you'll see these answers were given. This  
 11 particular copy is not signed, but -  
 12 MS. PREDHAM:  
 13 A. No, that must have been the last version I  
 14 got.  
 15 CHAYTOR, Q.C.:  
 16 Q. Okay. We have a version at 1852, please, and  
 17 you'll see that this version is signed, and I  
 18 believe it's dated May 10th, 2007.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CHAYTOR, Q.C.:  
 22 Q. I'll just take you to answer to question 10,  
 23 as to paragraph 29--so this was asking, I take  
 24 it, for clarification on certain answers that  
 25 you gave in your affidavit in February. "As

Page 226

1 to paragraph 29, what controls were run in all  
 2 instances", and you respond, "Technical  
 3 controls were run in all instances. Technical  
 4 controls are the inclusion of confirmed  
 5 positive control patient tissue samples".  
 6 Again, Ms. Predham, what would have been your  
 7 source of information on that?  
 8 MS. PREDHAM:  
 9 A. Mr. Gulliver.  
 10 CHAYTOR, Q.C.:  
 11 Q. And at the time of answering this, would you  
 12 have been aware that technical negative  
 13 controls were not run?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CHAYTOR, Q.C.:  
 17 Q. And you would have been aware of what Dr.  
 18 Banerjee found in terms of issues with  
 19 controls, and lack of internal controls, for  
 20 example?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CHAYTOR, Q.C.:  
 24 Q. And answer 11, "What is the hospital policy on  
 25 documentation of controls and on retention of

Page 227

1 documentation", and you write, "There is no  
 2 written hospital or lab policy on the  
 3 documentation of controls and the retention of  
 4 such documentation. As part of the lab's  
 5 policy, the technologists would enter the  
 6 date, time, and number of tests run and number  
 7 of controls run into the Meditech system. By  
 8 2001, with computer upgrades the technologists  
 9 included more particulars regarding the type  
 10 of test run. The pathologists would then sign  
 11 out the slides from the lab and produce a lab  
 12 report. The report should refer to both the  
 13 technical and internal controls run". What  
 14 was your source of information in answering  
 15 this interrogatory.  
 16 MS. PREDHAM:  
 17 A. Mr. Gulliver.  
 18 CHAYTOR, Q.C.:  
 19 Q. And what were the--this reference to the lab's  
 20 policy, you've indicated up here there's no  
 21 written policy, and what do you mean by, "as  
 22 part of the lab's policy"?  
 23 MS. PREDHAM:  
 24 A. It was--should probably say practice rather  
 25 than policy.

Page 228

1 CHAYTOR, Q.C.:  
 2 Q. And then question number 13, "Does the  
 3 documentation--you'll see 12 says, "What were  
 4 the controls used during the analytic phase  
 5 from paraffin section to the staining machine  
 6 antigen retrieval", and you just refer back to  
 7 10 and 11 as your answers, and 13 is, "Does  
 8 the documentation show the controls were  
 9 working in all documented cases", and you  
 10 write, "Not all pathologists referred to the  
 11 technical and internal controls in their  
 12 reports. I estimate that 50 percent of all  
 13 cases, the pathologist referred to the  
 14 technical controls in his or her report".  
 15 Where did you get that estimate of 50 percent?  
 16 MS. PREDHAM:  
 17 A. Mr. Gulliver.  
 18 CHAYTOR, Q.C.:  
 19 Q. And what was the source of his information?  
 20 MS. PREDHAM:  
 21 A. He had reviewed all the pathology reports at  
 22 the beginning of this process.  
 23 CHAYTOR, Q.C.:  
 24 Q. And why does the answer--so you're referring  
 25 to technical and internal controls, so meaning

Page 229

1 the external controls, I take it, external  
 2 positive controls?  
 3 MS. PREDHAM:  
 4 A. The technical, that's how it's defined up  
 5 above.  
 6 CHAYTOR, Q.C.:  
 7 Q. Well, it refers to documentation show that  
 8 controls were working.  
 9 MS. PREDHAM:  
 10 A. The previous answer, it said the technical  
 11 control was a positive control.  
 12 CHAYTOR, Q.C.:  
 13 Q. I'm sorry?  
 14 MS. PREDHAM:  
 15 A. In a previous answer that you read out -  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes.  
 18 MS. PREDHAM:  
 19 A. It said that the technical controls are the  
 20 confirmed positive.  
 21 CHAYTOR, Q.C.:  
 22 Q. Right here, yes.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CHAYTOR, Q.C.:

Page 230

1 Q. "Are the inclusion of confirmed positive  
 2 control", that's right. Were you aware of any  
 3 other documentation--it says, "Does the  
 4 documentation show the controls were working  
 5 in all documented cases". When signing these  
 6 answers in May of 2007, were you aware of any  
 7 other documentation that may have suggested  
 8 that controls were not working in all  
 9 documented cases?  
 10 MS. PREDHAM:  
 11 A. No.  
 12 CHAYTOR, Q.C.:  
 13 Q. For example, the fact that Dr. Banerjee had  
 14 found and written in his report that internal  
 15 controls were absent in certain cases that he  
 16 reviewed?  
 17 MS. PREDHAM:  
 18 A. They were--they were absent in certain cases.  
 19 CHAYTOR, Q.C.:  
 20 Q. Yes, and the existence of his report is  
 21 documentation to show that controls may not  
 22 have worked in all cases. I take it you  
 23 didn't drawn that--you didn't think about Dr.  
 24 Banerjee's report and whether or not that's a  
 25 document suggesting that controls may not have

Page 231

1 worked in all cases?  
 2 MS. PREDHAM:  
 3 A. No, I didn't--I didn't make that connection.  
 4 I was thinking more the pathology reports.  
 5 CHAYTOR, Q.C.:  
 6 Q. Did anyone besides Mr. Gulliver assist you in  
 7 the answers to these interrogatories?  
 8 MS. PREDHAM:  
 9 A. I don't believe. I think Mr. Gulliver was the  
 10 main source of information.  
 11 CHAYTOR, Q.C.:  
 12 Q. If I could have, please, P-1263. This is an  
 13 e-mail, May 31st, 2007, "In relation to recent  
 14 developments, I'm going to need information  
 15 from a claim's perspective asap, and you're  
 16 going to need a complete set of all the  
 17 minutes of the surgical pathology review  
 18 committee, was there any similar committee in  
 19 existence before this; if so, will need those  
 20 minutes as well. I also need a good  
 21 description of the other antibodies listed in  
 22 the April 4th '03 memo, how many tests have  
 23 been run using these antibodies, when did we  
 24 start and stop. I guess what I need is a  
 25 complete description of all IHC tests and

Page 232

1 dates, hat concerns have we been having in  
 2 these areas". So why on May 31st, 2007, did  
 3 this become an issue and that you now needed  
 4 information around these points?  
 5 MS. PREDHAM:  
 6 A. I think all three Dr. Ejeckam memos were  
 7 released that day; if not that day, it must  
 8 have been the day before, but I think it was  
 9 that day and I hadn't seen--I was provided  
 10 with a copy of the April 4th memo, and I  
 11 hadn't seen that one before.  
 12 CHAYTOR, Q.C.:  
 13 Q. And did you receive answers to the questions  
 14 that you posed?  
 15 MS. PREDHAM:  
 16 A. I believe I did.  
 17 CHAYTOR, Q.C.:  
 18 Q. And who provided you with those answers?  
 19 MS. PREDHAM:  
 20 A. I think it was Mr. Gulliver and Dr. Cook.  
 21 CHAYTOR, Q.C.:  
 22 Q. So you were able to get--for example, "was  
 23 there a similar committee in existence before  
 24 surgical pathology review committee".  
 25 MS. PREDHAM:

Page 233

1 A. I did get the answer, but there wasn't one.  
 2 CHAYTOR, Q.C.:  
 3 Q. There wasn't, and "how many tests were run  
 4 using the other antibodies, when they started  
 5 and stopped", all of those dates were, and the  
 6 information that was provided to you?  
 7 MS. PREDHAM:  
 8 A. I can't recall it right now, but I would  
 9 assume that--I know I had discussions with  
 10 them after, and I assume I would have had  
 11 those answers.  
 12 THE COMMISSIONER:  
 13 Q. So when in this communication one speaks of  
 14 the antibodies, you're referring to the other  
 15 antibodies referred to in the Ejeckam memos?  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 THE COMMISSIONER:  
 19 Q. Not the broad range of IHC testing?  
 20 MS. PREDHAM:  
 21 A. No, just the ones that are in that memo.  
 22 THE COMMISSIONER:  
 23 Q. Thank you.  
 24 CHAYTOR, Q.C.:  
 25 Q. If we could have, please, 472, and I'll just

Page 234

1 take you to the third page of this first.  
 2 This is an e-mail exchange that begins with  
 3 Mr. Thompson, Robert Thompson, to Mr. Tilley,  
 4 on June 7th, 2007, re; patient contact. "We  
 5 keep on hearing through the media about  
 6 patients who say they were not contacted in  
 7 2005 about their retest, yet your media  
 8 material is clear that all retest patients  
 9 were contacted in October, 2005. How do we  
 10 reconcile this? A short quick reply will be  
 11 appreciated as this may arise in the House in  
 12 an hour", and Ms. Predham, were you also  
 13 hearing that in the media at that time that  
 14 there were patients who were saying they were  
 15 never contacted?  
 16 MS. PREDHAM:  
 17 A. I must have been. I can't remember that now.  
 18 CHAYTOR, Q.C.:  
 19 Q. Were you aware that Eastern Health's media  
 20 material suggested otherwise?  
 21 MS. PREDHAM:  
 22 A. I certainly didn't pick it up at the time.  
 23 CHAYTOR, Q.C.:  
 24 Q. And Mr. Tilley forwards on to yourself and  
 25 others, "Can I get a quick note on this as

Page 235

1 quickly as possible", and then you respond to  
 2 the group, including Mr. Tilley, "In October,  
 3 2005, all patients that were identified at  
 4 that time as part of the retesting were  
 5 contacted by our department. These were calls  
 6 to inform them that they had been identified  
 7 as ER negative and will be retested". Ms.  
 8 Predham, is that correct, in October, 2005,  
 9 were you able to contact all the patients who  
 10 had been identified?  
 11 MS. PREDHAM:  
 12 A. No.  
 13 CHAYTOR, Q.C.:  
 14 Q. So why did you tell that to Mr. Tilley?  
 15 MS. PREDHAM:  
 16 A. That was an--that was incorrect at the time.  
 17 CHAYTOR, Q.C.:  
 18 Q. Do you know why you would have told him that?  
 19 MS. PREDHAM:  
 20 A. No, I don't, I just made a mistake.  
 21 CHAYTOR, Q.C.:  
 22 Q. "At the same time, ads were put in the paper,  
 23 media interviews were held, the patient  
 24 relations number was put in the paper, and  
 25 patients were told if they had questions or

Page 236

1 were not contacted by us to please call us.  
 2 Between our list and the calls we have  
 3 received, we felt we had a comprehensive list  
 4 of all those scheduled to be retested.  
 5 However, during the past few years we have  
 6 gotten an occasional call from someone who did  
 7 not make the original list. There have been a  
 8 variety of reasons. I must note that we still  
 9 get calls from people who say they weren't  
 10 called, but who were always ER positive and  
 11 not part of the retesting. When the results  
 12 came back, the patients who were confirmed  
 13 negative were notified by the particular  
 14 region, while the patients whose results were  
 15 changed, were notified by letter through their  
 16 physician. I hope this clarifies". In terms  
 17 of stating that the patients whose results  
 18 were changed were notified by letter through  
 19 their physicians, did you know in June of 2007  
 20 whether or not that, in fact, was the case?  
 21 MS. PREDHAM:  
 22 A. I could have said that a bit more clearly,  
 23 that it wasn't--all patients weren't  
 24 contacted.  
 25 CHAYTOR, Q.C.:

Page 237

1 Q. The plan was that patients would be -  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. - contacted in that manner, but whether or not  
 6 they had been, you did not know for sure?  
 7 MS. PREDHAM:  
 8 A. No.  
 9 CHAYTOR, Q.C.:  
 10 Q. Because your efforts to try and contact all  
 11 the physicians, that effort had never been  
 12 completed?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. And then Mr.--that gets forwarded on to Mr.  
 17 Thompson and Mr. Thompson replies, "George,  
 18 the return e-mail has unnerved us. Let me  
 19 explain" and he goes on with a fairly lengthy  
 20 e-mail which starts with "in December 2006,  
 21 Eastern Health told the media that in October  
 22 2005 patient relations representatives  
 23 telephoned all individuals whose specimens  
 24 were sent away for retesting. On May 18th,  
 25 2007, Eastern Health repeated this message in

Page 238

1 the media."  
 2 So Ms. Predham, in December 2006, when  
 3 Eastern Health indicated that all individuals  
 4 had been--whose specimens had been sent away  
 5 for retesting had been contacted, at that  
 6 time, did you pick up on it and express any  
 7 concern that that may not be an accurate  
 8 statement?  
 9 MS. PREDHAM:  
 10 A. I didn't pick up on it.  
 11 CHAYTOR, Q.C.:  
 12 Q. And again, when that was being repeated in May  
 13 of 2007, it didn't occur to you then?  
 14 MS. PREDHAM:  
 15 A. No.  
 16 CHAYTOR, Q.C.:  
 17 Q. If we could have, please, P-1268? This is a  
 18 copy of the ad, "a Message to the Public" and  
 19 were you provided a copy of this at the time?  
 20 MS. PREDHAM:  
 21 A. I don't think so.  
 22 CHAYTOR, Q.C.:  
 23 Q. You don't believe you received a copy?  
 24 MS. PREDHAM:  
 25 A. I can't remember. I may have, but I can't

Page 239

1 remember.  
 2 CHAYTOR, Q.C.:  
 3 Q. And do you recall seeing it then in the media?  
 4 MS. PREDHAM:  
 5 A. I saw it in the paper.  
 6 CHAYTOR, Q.C.:  
 7 Q. And it says, in bold, "we have always been  
 8 upfront and open with our patients. An  
 9 impression has been left with the public that  
 10 patients affected by the ER/PR review were not  
 11 contacted or given their own health  
 12 information. This is not true. Our first  
 13 priority is and always has been quality  
 14 patient care. That's why in 2005 when these  
 15 issues came to our attention, we acted  
 16 immediately to put safeguards in place. We  
 17 called all patients whose samples were being  
 18 retested. We informed all patients and their  
 19 doctors of their individual test results."  
 20 And Ms. Predham, when you did see this, did  
 21 those assertions cause you any concern?  
 22 MS. PREDHAM:  
 23 A. I didn't pick up on it.  
 24 CHAYTOR, Q.C.:  
 25 Q. So I take it you didn't bring it to the

Page 240

1 attention of anyone that that in fact was not  
 2 the case?  
 3 MS. PREDHAM:  
 4 A. No.  
 5 CHAYTOR, Q.C.:  
 6 Q. If I could have, please, P-1273? This is from  
 7 yourself to Mr. Tilley and Pam Elliott.  
 8 "We've added our thoughts in blue below" and  
 9 that won't come out here. "I'm here if you  
 10 need to clarify anything. The number of  
 11 patients increased from 424 to 835 in a month,  
 12 then it kept going." And what are you trying  
 13 to say there by mentioning the increase in  
 14 patients within a period of one month?  
 15 MS. PREDHAM:  
 16 A. Well, I think that I had a discussion with Mr.  
 17 Thompson in between that and he was under the  
 18 impression, from our media releases, that all  
 19 patients, all 939 were contacted in October  
 20 2005. So I guess I was just saying--I was  
 21 just reiterating that at that time in October  
 22 2005, we weren't aware of everybody at that  
 23 time.  
 24 CHAYTOR, Q.C.:  
 25 Q. If we could look at 1272, please? So before

Page 241

1 we leave this one then--sorry, Registrar. Mr.  
 2 Thompson is saying that "the key question is  
 3 whether Eastern Health's statements that all  
 4 patients were contacted in October 2005 is  
 5 accurate. The short answer is that every  
 6 patient who they had identified for retesting  
 7 by October 2005 was contacted by telephone at  
 8 that time." But is that statement correct?  
 9 MS. PREDHAM:  
 10 A. No. It should have been that every patient--  
 11 it was attempted to contact every patient at  
 12 that time.  
 13 CHAYTOR, Q.C.:  
 14 Q. Even the ones--there were patients that you  
 15 knew about that you still weren't able to  
 16 contact?  
 17 MS. PREDHAM:  
 18 A. Yes. Very few, but we couldn't get them.  
 19 CHAYTOR, Q.C.:  
 20 Q. And if we could look then at 1272? Did you  
 21 take that up with anyone and try to correct  
 22 that statement that Mr. Thompson was under the  
 23 impression of, the one that I just pointed you  
 24 to? Did you mention that to anyone "oh,  
 25 that's still not correct. That's not -

Page 242

1 MS. PREDHAM:  
 2 A. There was--as you can imagine, this was a very  
 3 intense time and I didn't pick that up until  
 4 much later.  
 5 CHAYTOR, Q.C.:  
 6 Q. And this is an e-mail same date, between Mr.  
 7 Thompson and Mr. Tilley, and actually, I think  
 8 this is the same, and there was another  
 9 portion in it. In the bottom, he says "this  
 10 is a summary of today's conversation between  
 11 Heather, you and me." So this is, I take it  
 12 you've had a discussion with -  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 CHAYTOR, Q.C.:  
 16 Q. - Mr. Tilley and Mr. Thompson on this date.  
 17 "Would you please let me know whether it  
 18 properly captures the facts. I will call  
 19 you." And there is that fact that you're  
 20 saying you didn't take it up with him about  
 21 every patient because of what's happening in  
 22 this time period, and "in conclusion, we are  
 23 informed by Eastern Health that all people who  
 24 had been identified for retests by October  
 25 2005 were called in October 2005, except for

Page 243

1 some people whose results were already back  
 2 from Mount Sinai. Some more people"--and I  
 3 take it that because they had already been -  
 4 MS. PREDHAM:  
 5 A. Informed.  
 6 CHAYTOR, Q.C.:  
 7 Q. Right, or were in the process of being  
 8 informed. "Some more people though we told,  
 9 it was a small number, were identified after  
 10 October 2005 and may not have been called."  
 11 So the idea that everyone you knew of in  
 12 October 2005 having been called in October  
 13 2005, I take it that's not accurate either?  
 14 MS. PREDHAM:  
 15 A. No, and the focus of our conversation was, as  
 16 Mr. Thompson felt the 939 or the patients that  
 17 were alive of those had been called. I didn't  
 18 pick up until after the fact that, you know,  
 19 we had attempted to contact everybody, but  
 20 didn't get in there. The whole thing was  
 21 trying to explain that we didn't know  
 22 everybody in October 2005.  
 23 CHAYTOR, Q.C.:  
 24 Q. P-1957, please, Registrar? This is a copy of  
 25 Dr. Banerjee's report with a Post-it on it,

Page 244

1 and it says "July 25th, 2007, from Heather,  
 2 for your perusal" and who is DP?  
 3 MS. PREDHAM:  
 4 A. Debbie Parsons.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, and this is copy three of four, and who,  
 7 on July 25th, 2007, or thereabouts, did you  
 8 provide a copy of Dr. Banerjee's report to?  
 9 MS. PREDHAM:  
 10 A. I think it was Pam Elliott.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay, and why?  
 13 MS. PREDHAM:  
 14 A. Because she was referenced on the--I'm pretty  
 15 sure on the report or something that Dr.  
 16 Williams had there that the copy was for me  
 17 and her as well, and she had not gotten a  
 18 copy.  
 19 CHAYTOR, Q.C.:  
 20 Q. And how did that come up in July of 2007?  
 21 MS. PREDHAM:  
 22 A. I think when we were going through things and  
 23 discussing it, she saw that her name was  
 24 copied. It was for Heather Predham/Pam  
 25 Elliott on it and that she hadn't gotten a

Page 245

1 copy.  
 2 CHAYTOR, Q.C.:  
 3 Q. And 1420, please? And this is a letter of  
 4 September 19th, 2007 to Ms. Marian Crowley and  
 5 it was signed by a number of physicians. This  
 6 originated, we understand, out of the letter  
 7 that was sent to patients with respect to the  
 8 class action, and patients had to be--there  
 9 was a Court order that letters be sent out.  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 CHAYTOR, Q.C.:  
 13 Q. And patients be notified. What was your  
 14 involvement in the letter that went out to  
 15 patients?  
 16 MS. PREDHAM:  
 17 A. I had minimal involvement because I was on  
 18 holidays those two weeks. Ms. Crowley did  
 19 contact me. I knew there was one going out,  
 20 like in the future, but I didn't realize the  
 21 time line. Ms. Crowley did call me at home  
 22 during that period of time to tell me that  
 23 they were notified that we had to provide the  
 24 names and addresses at that time to the law  
 25 firm, and that they were going to send out a

Page 246

1 letter, and the Court order stated that the  
 2 notification of the class action law suit  
 3 would be in the papers, but that people who  
 4 had gone from ER negative to ER positive were  
 5 required by the Court to receive a letter, and  
 6 Marian called me to try to identify how to--  
 7 how was she going to identify who those  
 8 patients would be, easily.  
 9 I did check with legal counsel at the  
 10 time, just to get the content of the letter,  
 11 of what would be in that, what type of letter  
 12 it would be, and my understanding, and both  
 13 Mrs. Crowley's understanding is the letter  
 14 would be fairly innocuous. It would just be  
 15 "this is a Court--we are required by the Court  
 16 order to notify you of this class action law  
 17 suit. Please find the order attached" or  
 18 something on that line. So my feeling was  
 19 that all the patients on the panel list would  
 20 cover off that conversion. At least she'd  
 21 have a good bulk of them and we could get that  
 22 out before the date.  
 23 CHAYTOR, Q.C.:  
 24 Q. And which panel list is that?  
 25 MS. PREDHAM:

Page 247

1 A. All the patients that were panelled, all the  
 2 people.  
 3 CHAYTOR, Q.C.:  
 4 Q. Every patient that was panelled?  
 5 MS. PREDHAM:  
 6 A. Yes. So that's what Mrs. Crowley did, got the  
 7 names and the addresses for those patients,  
 8 but found out, I think it was the Wednesday  
 9 before the Friday it had to be in the mail,  
 10 that Eastern Health had to send out the  
 11 letter, and she did not get the letter until  
 12 Thursday 3:30-4:00. The letter had to be out  
 13 on Friday and, you know, they spent the day  
 14 trying to--as we mentioned earlier about the  
 15 logistics of actually getting a letter out and  
 16 she actually had to go to the post office at  
 17 4:30, convince the man at the post office to  
 18 stay late and charged it all on her credit  
 19 card to get the registered letters out by that  
 20 day.  
 21 CHAYTOR, Q.C.:  
 22 Q. Okay, and the content of the letter and what  
 23 the oncologists are taking issue with here is  
 24 that there was erroneous information in the  
 25 letter, that it referred to those individuals

Page 248

1 whose breast cancer screening results  
 2 converted.  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. And did anyone notice--did you or Ms.--did you  
 7 even see the letter before it went out?  
 8 MS. PREDHAM:  
 9 A. No, I didn't, no.  
 10 CHAYTOR, Q.C.:  
 11 Q. And so did anyone else notice that--before the  
 12 letter was sent, that it was erroneous in  
 13 referring to breast cancer screening?  
 14 MS. PREDHAM:  
 15 A. No.  
 16 CHAYTOR, Q.C.:  
 17 Q. Were there any inquiries made as to whether or  
 18 not anything in the letter could be changed?  
 19 MS. PREDHAM:  
 20 A. There was, and Ms. Crowley was under the  
 21 understanding that this was a Court approved  
 22 letter and that she couldn't change anything.  
 23 CHAYTOR, Q.C.:  
 24 Q. And who gave her that understanding?  
 25 MS. PREDHAM:

Page 249

1 A. Legal counsel, our legal counsel.  
 2 CHAYTOR, Q.C.:  
 3 Q. And did you have any other discussions with  
 4 anyone else in terms of coordinating who, for  
 5 example, would get the letter?  
 6 MS. PREDHAM:  
 7 A. No.  
 8 CHAYTOR, Q.C.:  
 9 Q. Or otherwise have any other dealings with  
 10 respect to this?  
 11 MS. PREDHAM:  
 12 A. To the issue or to the -  
 13 CHAYTOR, Q.C.:  
 14 Q. To the letter going out to the patients with  
 15 this statement that it concerned breast cancer  
 16 screening?  
 17 MS. PREDHAM:  
 18 A. No, that was my only contact.  
 19 CHAYTOR, Q.C.:  
 20 Q. And if we could have, please, P-1427? And  
 21 this is a follow up to October 1st meeting.  
 22 It's October 4th '07 from yourself to a bunch  
 23 of people. "As promised, the last meeting for  
 24 discussion. I'm circulating two options for a  
 25 possible letter for communicating the results

Page 250

1 of the deceased" and you've done two options.  
 2 So I take it, at this point in time, there's  
 3 still a plan that there's going to be letters  
 4 go to the families of the deceased patients?  
 5 MS. PREDHAM:  
 6 A. I was trying to move the decision along. So I  
 7 decided if I'd at least have something  
 8 concrete that we could talk about, at least  
 9 that would make people consider what we're  
 10 doing. Because we hadn't come up with a  
 11 decision yet.  
 12 CHAYTOR, Q.C.:  
 13 Q. And basically, what was the difference in your  
 14 two options that you were proposing?  
 15 MS. PREDHAM:  
 16 A. One, I think, was telling them the results,  
 17 the straight out, because that was--some  
 18 people felt we should just disclose the  
 19 information, which I didn't agree with, and  
 20 others--the other one was just to notify that  
 21 the results were available if you'd like to  
 22 have them.  
 23 CHAYTOR, Q.C.:  
 24 Q. Okay, and if we could have, please, P-3076?  
 25 And Ms. Pilgrim is responding to you the same

Page 251

1 day, "I also prefer the first option. The  
 2 question you ask is very interesting. I will  
 3 consider that we use the same line we always  
 4 do, you know the one that is, or we could talk  
 5 to the Cancer Centre to have them take over  
 6 this time," and I think your question that you  
 7 had asked "thank you for your responses so  
 8 far, but don't forget to consider options as  
 9 to who is going to sign this letter and who is  
 10 going to talk to the patients whose oncologist  
 11 is no longer practising here?" What did you  
 12 understand Ms. Pilgrim to be telling you, "I  
 13 will consider we use the same line we always  
 14 do...you know which one that is."  
 15 MS. PREDHAM:  
 16 A. I can't think of what that would be right now.  
 17 If I didn't understand it, I would have called  
 18 her.  
 19 CHAYTOR, Q.C.:  
 20 Q. You have no idea what that refers to?  
 21 MS. PREDHAM:  
 22 A. Right now, I don't.  
 23 CHAYTOR, Q.C.:  
 24 Q. If we could have, please, P-2692? And you  
 25 send out this e-mail to people in the lab.

Page 252

1 "Nancy is getting numerous calls from the  
 2 families of the deceased who are waiting for  
 3 results. She is off today and I answered two  
 4 of the calls and they are upset about the time  
 5 they are waiting, so any word? Any time  
 6 line?" And this is October 5th, 2007. So at  
 7 this point in time, you're receiving and the  
 8 Quality department is receiving frequent calls  
 9 from families of the deceased patients?  
 10 MS. PREDHAM:  
 11 A. Yes. I think the specimens went away in July.  
 12 I may be mistaken, but I think they did, and  
 13 as you can see, by October, we hadn't gotten  
 14 anything back.  
 15 CHAYTOR, Q.C.:  
 16 Q. And P-3077, please? This is an e-mail from  
 17 Ms. Pilgrim to Terry Gulliver and copied to  
 18 you. It's October 23rd, 2007. "Terry, I need  
 19 to talk to you about the NLCHI list. In going  
 20 over the list with Heather, there appears to  
 21 be information that we could have provided  
 22 that we did not." What's that referring to?  
 23 MS. PREDHAM:  
 24 A. This is, I guess, results that we could have  
 25 shared, I think. The most of going through

Page 253

1 the NLCHI list was--where they were--they had  
 2 questions, so they were trying to compile  
 3 their own list and anything that they couldn't  
 4 clearly reconcile, they would come back with  
 5 the questions for us to clarify on.  
 6 CHAYTOR, Q.C.:  
 7 Q. Is this information though that could have  
 8 been provided to NLCHI that wasn't provided or  
 9 wasn't provided to whom?  
 10 MS. PREDHAM:  
 11 A. Oh, it may be that. I just -  
 12 CHAYTOR, Q.C.:  
 13 Q. Who did you understand it was? And I don't  
 14 know if that's what it is, but -  
 15 MS. PREDHAM:  
 16 A. I would have understood it at the time, and  
 17 my--all the rest of them is about patients,  
 18 certain patients and which ones that we knew  
 19 and the different numbers. So it was that  
 20 type of thing, and but maybe it is. Maybe it  
 21 is some information that he would have had  
 22 that we hadn't given to NLCHI.  
 23 CHAYTOR, Q.C.:  
 24 Q. And do you know what the answer was as to why  
 25 it hadn't been provided?

Page 254

1 MS. PREDHAM:  
 2 A. I can't remember.  
 3 CHAYTOR, Q.C.:  
 4 Q. And if we could have, please, P-3078? And  
 5 this is an e-mail from you to Ms. Pilgrim and  
 6 Mr. Gulliver, October 24th. "Here's a  
 7 synopsis of what came out of this morning's  
 8 meeting. Page me if you need to talk about  
 9 it. Patients that have been identified as not  
 10 having been retested previously at Mount Sinai  
 11 and whose specimens have been sent, either in  
 12 September or October," and you've listed nine  
 13 people. "As of right now, these are the only  
 14 patients that would have to be contacted. We  
 15 need to confirm that we are calling all of  
 16 these patients and we also need a carefully  
 17 worded script as to what exactly we are going  
 18 to say to explain about the late contact. We  
 19 also need a decision if we will or will not  
 20 call the patients who have been on Tamoxifen."  
 21 Ms. Predham, why do you need a carefully  
 22 worded script as to exactly what you're going  
 23 to say to explain the late contact?  
 24 MS. PREDHAM:  
 25 A. Well, I just wanted to make sure, you know,

Page 255

1 what were we saying to people when we called  
 2 them up to say that they were missed in our  
 3 first review.  
 4 CHAYTOR, Q.C.:  
 5 Q. And why not just tell them what happened?  
 6 MS. PREDHAM:  
 7 A. Oh, that's what we did.  
 8 CHAYTOR, Q.C.:  
 9 Q. And was there a script ever drafted?  
 10 MS. PREDHAM:  
 11 A. I don't think so.  
 12 CHAYTOR, Q.C.:  
 13 Q. And what reason was given to the patients as  
 14 to why it was so late that they are being  
 15 identified and tested?  
 16 MS. PREDHAM:  
 17 A. Well, it took us a while to figure out why  
 18 people were missed. There was a variety of  
 19 different reasons. I didn't give them a  
 20 reason at that time. I told them that when we  
 21 went through the list, we thought we had  
 22 everybody and we have now discovered that your  
 23 results--your specimen was not retested.  
 24 CHAYTOR, Q.C.:  
 25 Q. And why would you need a decision if you will

Page 256

1 or will not contact the patients who have been  
 2 on Tamoxifen?  
 3 MS. PREDHAM:  
 4 A. It must have come up in discussions and I just  
 5 wanted to make sure that it was not anything  
 6 that was going to--before I called people, I  
 7 needed to make sure that that was not anything  
 8 that was--we were going to do. We were going  
 9 to stay with the same plan.  
 10 CHAYTOR, Q.C.:  
 11 Q. Yes, because the vast majority of patients  
 12 who'd been retested, the plan had always been,  
 13 regardless if they were on Tamoxifen or not,  
 14 they were contacted and told.  
 15 MS. PREDHAM:  
 16 A. Yes, but -  
 17 CHAYTOR, Q.C.:  
 18 Q. So was it -  
 19 MS. PREDHAM:  
 20 A. - somewhere along the way, it must have come  
 21 up again, and I just wanted to make sure  
 22 before I called anybody.  
 23 CHAYTOR, Q.C.:  
 24 Q. Was there somebody suggesting or contemplating  
 25 that these patients, these nine patients would



Page 257

1 be treated any differently than the other  
 2 patients who had been contacted much earlier?  
 3 MS. PREDHAM:  
 4 A. I don't recall specifically, but there must  
 5 have been some question in my mind that there  
 6 was that consideration by--or a suggestion  
 7 made and I just wanted to make sure.  
 8 CHAYTOR, Q.C.:  
 9 Q. If we could have--then were you involved in  
 10 contacting these people?  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CHAYTOR, Q.C.:  
 14 Q. If we could have, please, P-2875? And this is  
 15 a fairly lengthy--it's November 3rd now and  
 16 you're writing this to Louise Jones, Pat  
 17 Pilgrim and others and it's a final update and  
 18 you give a list of--what is this and what are  
 19 you doing here?  
 20 MS. PREDHAM:  
 21 A. Contacting those individuals on the previous  
 22 one that we had identified had not been  
 23 retested.  
 24 CHAYTOR, Q.C.:  
 25 Q. Okay, and so this is the result of your

Page 258

1 efforts in that regard?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay, and if we could, I think it's page three  
 6 of this document. There's a patient here, and  
 7 I believe this is Dr. Laing's name. "This is  
 8 Dr. Laing's patient and she feels that she  
 9 should not be contacted. Louise suggested a  
 10 quick ethical discussion on the circumstances.  
 11 I'll try to do that later today."  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 CHAYTOR, Q.C.:  
 15 Q. What was the circumstances around that  
 16 patient?  
 17 MS. PREDHAM:  
 18 A. I really don't know how to -  
 19 CHAYTOR, Q.C.:  
 20 Q. Without -  
 21 MS. PREDHAM:  
 22 A. It's such a unique situation, I don't know how  
 23 to describe it without identifying the  
 24 patient, but -  
 25 CHAYTOR, Q.C.:

Page 259

1 Q. Is there any issue in terms of, for example,  
 2 the patient's competency?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CHAYTOR, Q.C.:  
 6 Q. Okay, and did an ethical consult take place?  
 7 MS. PREDHAM:  
 8 A. I think Louise contacted Dr. Singleton. We  
 9 went ahead and contacted the patient.  
 10 CHAYTOR, Q.C.:  
 11 Q. And if we could have 1538, please? This is  
 12 the same reference to that patient, I believe.  
 13 Okay, and if we could have, please--I just  
 14 want to make sure that, in fact, it was Dr.  
 15 Laing's.  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 CHAYTOR, Q.C.:  
 19 Q. I was questioning my memory on that.  
 20 MS. PREDHAM:  
 21 A. Oh, I remember.  
 22 CHAYTOR, Q.C.:  
 23 Q. Okay, sorry. If we could have, please, P-  
 24 3439? And this is an e-mail from Ms. Pilgrim  
 25 to yourself, amongst others, about the weak

Page 260

1 positive review, and what do you know about  
 2 this issue and how it came up at this point in  
 3 time and what the ultimate decision was made  
 4 in terms of whether or not to review the weak  
 5 positives?  
 6 MS. PREDHAM:  
 7 A. I wasn't, other than being copied on this e-  
 8 mail and maybe another one, I wasn't involved  
 9 in this. I do know it came out of testimony  
 10 from the Inquiry about a particular patient  
 11 who was beyond our parameters who did not get  
 12 Tamoxifen.  
 13 CHAYTOR, Q.C.:  
 14 Q. Okay, and P-3445, please? I'm into my last  
 15 book. That's a good sign.  
 16 MS. PREDHAM:  
 17 A. Oh, good.  
 18 CHAYTOR, Q.C.:  
 19 Q. Just going to take you to the last page then  
 20 of this document, or page three anyhow, sorry.  
 21 I think this will give us the sense of what's  
 22 going on here.  
 23 MS. PREDHAM:  
 24 A. It was a very complicated issue.  
 25 CHAYTOR, Q.C.:

Page 261

1 Q. Okay. So you do remember about this issue?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 CHAYTOR, Q.C.:  
 5 Q. Okay. Well then, perhaps you could just tell  
 6 us then, this is in June of 2008, and what you  
 7 recall about the circumstances of this  
 8 particular patient?  
 9 MS. PREDHAM:  
 10 A. I think she wrote to Ms. Jones, had some  
 11 concerns, and in investigating it then, of  
 12 course it came forward--investigating that, we  
 13 discovered that she did meet the criteria but  
 14 not had been identified for retesting, and--  
 15 can I just -  
 16 CHAYTOR, Q.C.:  
 17 Q. Yes, please, go ahead.  
 18 MS. PREDHAM:  
 19 A. But there were--it was hard to track the time  
 20 line of what happened. She had already spoken  
 21 to Nancy and she did get retested, but the  
 22 communication was very unclear, and I believe  
 23 Ms. Smith ultimately followed up with her.  
 24 This was my preliminary review of it and Ms.  
 25 Laidley had more information to add to that.

Page 262

1 CHAYTOR, Q.C.:  
 2 Q. Okay, and I think if we go to page one, we'll  
 3 see that Ms. Laidley does a bit of a  
 4 chronology of what she's able to piece  
 5 together. She's reviewed the chart.  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And pathology reports, and she spoke with  
 10 pathology in Carbonear, and she goes through  
 11 the fact that the patient had a biopsy and a  
 12 partial mastectomy and then ER/PR at that time  
 13 was ER negative, PR 20 to 25 positive. She  
 14 comes down in number eight, "in December of  
 15 2003, had a biopsy done of chest wall with  
 16 diagnosis of recurrence of infiltrating ductal  
 17 carcinoma. And then January 2004, referred to  
 18 Cancer Clinic and was seen by Dr. McCarthy.  
 19 In speaking with the patient, she decided to  
 20 request a repeat of ER/PR. Repeat was done  
 21 which showed ER positive, 60 to 70 and PR  
 22 positive 50 to 60." So I take it, Ms.  
 23 Predham, there was a conversion in 2004 with  
 24 respect to this patient?  
 25 MS. PREDHAM:

Page 263

1 A. Yes.  
 2 CHAYTOR, Q.C.:  
 3 Q. And was there an incident report or an  
 4 occurrence report filled out in 2004 regarding  
 5 this?  
 6 MS. PREDHAM:  
 7 A. No, and I don't think that anyone identified  
 8 it at the time. I don't think anybody  
 9 identified the changed results at the time.  
 10 CHAYTOR, Q.C.:  
 11 Q. You don't think that was picked up by Dr.  
 12 McCarthy at the time?  
 13 MS. PREDHAM:  
 14 A. No, because if I remember rightly, and I think  
 15 it's referred to in Ms. Smith's letter, I  
 16 believe Dr. McCarthy went off on maternity  
 17 leave before the results came back.  
 18 CHAYTOR, Q.C.:  
 19 Q. And the next physician taking over her care  
 20 didn't pick up on it?  
 21 MS. PREDHAM:  
 22 A. No.  
 23 CHAYTOR, Q.C.:  
 24 Q. And then in November 2005--and I take it nor  
 25 did the pathologist who would have entered the

Page 264

1 addendum on her pathology report?  
 2 MS. PREDHAM:  
 3 A. Yes, it would have been done through Carbonear  
 4 and nobody picked it up there.  
 5 CHAYTOR, Q.C.:  
 6 Q. And on November, then November, the OPIS notes  
 7 indicate the patient was asking about her ER  
 8 and PR and Dr. Zulfiqar could not find them on  
 9 the computer. No results are available in PCI  
 10 because they went back to Carbonear for  
 11 reporting. It states he would request repeat  
 12 to those levels. And then she has a  
 13 recurrence in January 2007, and the OPIS notes  
 14 refer the results of ER/PR from the initial  
 15 diagnosis and not to the retesting in 2004,  
 16 and this patient is not in the database and  
 17 was not retested when retesting of ER negative  
 18 patients was set up. And why was it that she  
 19 wasn't retested when the overall retesting was  
 20 taking place.  
 21 MS. PREDHAM:  
 22 A. She didn't get identified through Carbonear.  
 23 CHAYTOR, Q.C.:  
 24 Q. And as you succinctly write, "There are  
 25 multiple--multitude of issues here".

Page 265

1 MS. PREDHAM:  
 2 A. Multitude of issues.  
 3 CHAYTOR, Q.C.:  
 4 Q. Multitude of issues. If I could have, please,  
 5 P-2633 and P-2634. Sorry, you only do one at  
 6 a time, don't you. I'm sorry. 2633 is good.  
 7 I'm really trying to rush now.  
 8 PIKE, Q.C.:  
 9 Q. Multitasking.  
 10 CHAYTOR, Q.C.:  
 11 Q. Getting good at that. This is physician panel  
 12 meeting then, June 5th, 2008, and I take it  
 13 you're back to doing minutes at this point?  
 14 MS. PREDHAM:  
 15 A. I'm not on that panel.  
 16 CHAYTOR, Q.C.:  
 17 Q. You're not on this panel.  
 18 MS. PREDHAM:  
 19 A. No.  
 20 CHAYTOR, Q.C.:  
 21 Q. Whoever is on it -  
 22 MS. PREDHAM:  
 23 A. Ms. Smith took my -  
 24 CHAYTOR, Q.C.:  
 25 Q. Ms. Gregory is now doing the -

Page 266

1 MS. PREDHAM:  
 2 A. Yes, and Ms. Smith is taking my position.  
 3 CHAYTOR, Q.C.:  
 4 Q. And why is that, why aren't you sitting on the  
 5 panel any more?  
 6 MS. PREDHAM:  
 7 A. Well, it was evident as it progressed, and I  
 8 think I mentioned this earlier, that someone  
 9 from the Cancer Clinic would have been best on  
 10 that panel because it was support from a  
 11 clinical--you know, support from a patient--  
 12 primarily a cancer clinic patient situation,  
 13 so Ms. Smith was not in that position at that  
 14 time, but she was now.  
 15 CHAYTOR, Q.C.:  
 16 Q. And do you any longer have any contact with  
 17 the patients on this issue?  
 18 MS. PREDHAM:  
 19 A. No.  
 20 CHAYTOR, Q.C.:  
 21 Q. For example, coming out of this now, whatever  
 22 decisions are made by any patients that are  
 23 being panelled or continued in through 2008 to  
 24 be identified, you weren't involved in the  
 25 contacting of those patients?

Page 267

1 MS. PREDHAM:  
 2 A. No.  
 3 CHAYTOR, Q.C.:  
 4 Q. And why was that decision made?  
 5 MS. PREDHAM:  
 6 A. Well, we had one of our staff, Ms. Laidley,  
 7 was working with the cancer clinic, so between  
 8 herself and Ms. Smith, they were doing all the  
 9 patient contact.  
 10 CHAYTOR, Q.C.:  
 11 Q. If we could have, please, P-3462. This is an  
 12 e-mail from Dianne Smith to yourself, and who  
 13 again is Dianne Smith?  
 14 MS. PREDHAM:  
 15 A. Ms. Pilgrim's administrative assistant.  
 16 CHAYTOR, Q.C.:  
 17 Q. She quotes James Joyce.  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 CHAYTOR, Q.C.:  
 21 Q. "Pat would like to talk to you in the morning  
 22 about the following; Janet Henley-Andrews  
 23 called this afternoon with the following  
 24 questions. One, was she ever panelled; two,  
 25 if she was, was a panel letter sent to her

Page 268

1 doctor, the name of the doctor/doctors panel  
 2 letter was sent to", and her contact  
 3 information, and this was sent to you, and  
 4 were you able to provide the answers to those  
 5 questions?  
 6 MS. PREDHAM:  
 7 A. Yes.  
 8 CHAYTOR, Q.C.:  
 9 Q. And was Ms. Henley-Andrews ever panelled?  
 10 MS. PREDHAM:  
 11 A. No.  
 12 CHAYTOR, Q.C.:  
 13 Q. And why not?  
 14 MS. PREDHAM:  
 15 A. When the information--she had contacted Nancy  
 16 in, I guess, October, 2005, and requested  
 17 testing, and--because she had not had an  
 18 original ER/PR done. At that time, Dr. Cook  
 19 agreed to send her off for testing and we  
 20 brought the results to a panel meeting in  
 21 November. Dr. Felix was her surgeon and her  
 22 treating physician, and there was some  
 23 discussion at the panel--I think this was the  
 24 first time I heard the discussion about DCIS,  
 25 and it was agreed that she didn't meet the

Page 269

1 criteria because she didn't have any original  
 2 results done, and I was of the impression that  
 3 Dr. Felix was contacting her with those  
 4 results.  
 5 CHAYTOR, Q.C.:  
 6 Q. And was Dr. Felix present at the time that  
 7 that was discussed?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CHAYTOR, Q.C.:  
 11 Q. So even though her name came up, you didn't  
 12 understand that you would have any involvement  
 13 in contacting her, you understood it was  
 14 tasked to Dr. Felix?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CHAYTOR, Q.C.:  
 18 Q. And was there anything put in the minutes  
 19 arising out of that panel meeting to indicate  
 20 that?  
 21 MS. PREDHAM:  
 22 A. I don't think so because she wasn't--she  
 23 didn't meet the criteria of being panelled.  
 24 CHAYTOR, Q.C.:  
 25 Q. We've also seen a previous exhibit in the

Page 270

1 Commission that information went back to the  
 2 government. Mr. Thompson had written a  
 3 letter, and Ms. Henley-Andrews happened to be  
 4 one of the patients that was being inquired  
 5 of, and the information that went back said  
 6 that she was, in fact, contacted or her  
 7 results given at a date which couldn't be the  
 8 accurate date. You're aware of that?  
 9 MS. PREDHAM:  
 10 A. Oh, yes.  
 11 CHAYTOR, Q.C.:  
 12 Q. Okay, and how did that happen?  
 13 MS. PREDHAM:  
 14 A. That was--that was my typo. I don't know how  
 15 I put in September instead of November, but  
 16 when the letter got over to the Centre for  
 17 Health Information, I got a call asking me was  
 18 I sure, and obviously I realized I had made a  
 19 mistake.  
 20 CHAYTOR, Q.C.:  
 21 Q. In any event, though, she wasn't provided her  
 22 results in November?  
 23 MS. PREDHAM:  
 24 A. No.  
 25 CHAYTOR, Q.C.:

Page 271

1 Q. So the information you were providing was  
 2 assuming that Dr. Felix had followed up and  
 3 given the information in November, 2005?  
 4 MS. PREDHAM:  
 5 A. Yes, it was an assumption.  
 6 CHAYTOR, Q.C.:  
 7 Q. Those are all my questions. Thank you very  
 8 much. I realize it's been quite a long time  
 9 for you. Thank you.  
 10 THE COMMISSIONER:  
 11 Q. Thank you, Ms. Chaytor. Mr. Pritchard.  
 12 MR. PRITCHARD:  
 13 Q. Commissioner, I don't have any questions for  
 14 this witness. Thank you for your evidence,  
 15 Ms. Predham.  
 16 THE COMMISSIONER:  
 17 Q. Mr. Browne.  
 18 BROWNE, Q.C.:  
 19 Q. No questions for the witness. Thank you very  
 20 much, Ms. Predham.  
 21 THE COMMISSIONER:  
 22 Q. Mr. Pritchett.  
 23 MS. HEATHER PREDHAM--EXAMINATION BY MR. BLAIR PRITCHETT  
 24 MR. PRITCHETT:  
 25 Q. Good afternoon, Ms. Predham. My name is Blair

Page 272

1 Pritchett. I'm here on behalf of the Western,  
 2 Central, and Grenfell Health Authorities. I  
 3 just have a few questions for you today. I  
 4 want to take you back to--I think it was  
 5 Saturday's evidence. I know you've been here  
 6 a while, but I think it was on Saturday. Ms.  
 7 Chaytor was talking to you about Trish  
 8 Wegrynowski's exit interview. Do you recall  
 9 that discussion somewhat?  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 MR. PRITCHETT:  
 13 Q. And a particular point I wanted to discuss  
 14 with you was I believe something in your notes  
 15 about considering a disclaimer on reports from  
 16 referral labs. Do you recall that issue  
 17 coming up at that time?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 MR. PRITCHETT:  
 21 Q. And from my own notes, I recall Ms. Chaytor  
 22 asking you that--speaking to you about the  
 23 concept that basically people who were  
 24 referring specimens in to Eastern Health would  
 25 need to or should be told if there were

Page 273

1 fixation problems that caused a compromised  
 2 result going back. In other words, if there  
 3 was something about the sample coming in that  
 4 might affect the result going out.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MR. PRITCHETT:  
 8 Q. And does that accord with your understanding  
 9 as well, that that came up?  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 MR. PRITCHETT:  
 13 Q. And I believe Ms. Chaytor went on to ask you  
 14 from your own position involved in quality and  
 15 risk management, would that stick out in your  
 16 mind during that discussion, and I believe you  
 17 said that would strike you as an important  
 18 issue at that point?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MR. PRITCHETT:  
 22 Q. And as I take it, the upshot of this  
 23 discussion that you had with Ms. Wegrynowski  
 24 was that you need to be advising referral  
 25 sources of problems if you're going to be

Page 274

1 reporting something back or sending a sample  
 2 back to them?  
 3 MS. PREDHAM:  
 4 A. That, as well as making it clear that if there  
 5 were problems there that they were aware of,  
 6 that it could influence the test. So it's a  
 7 two sided thing, that we're doing the test,  
 8 but we can't control what's happening in your  
 9 site, and, I guess, as well if there's  
 10 identification of issues, you have to  
 11 communicate that back.  
 12 MR. PRITCHETT:  
 13 Q. Yes. So you want to make sure that you're  
 14 properly communicating your own institutions  
 15 ability to do what you're undertaking to do?  
 16 MS. PREDHAM:  
 17 A. Exactly.  
 18 MR. PRITCHETT:  
 19 Q. And by the same token, from a patient safety  
 20 perspective, if you see an issue, you want to  
 21 make sure that the referring institution is  
 22 made aware of that?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 MR. PRITCHETT:

Page 275

1 Q. And that would affect not only the individual  
 2 patient in a particular case, but also  
 3 patients on a go forward basis as more cases  
 4 are being referred?  
 5 MS. PREDHAM:  
 6 A. Oh, definitely.  
 7 MR. PRITCHETT:  
 8 Q. And the idea being if there is some sort of  
 9 consistent problem, flagging it early and  
 10 often, if unfortunately that is the case,  
 11 would hopefully raise the antenna of the  
 12 people sending you the samples?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 MR. PRITCHETT:  
 16 Q. And again, I guess, from that discussion, I  
 17 take it that in your world, the view would be  
 18 if you get a report or a sample come back from  
 19 an institution and that's unqualified or  
 20 unequivocal in what it's saying, that  
 21 effectively you take it at face value? You  
 22 know, if you get a report -  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 MR. PRITCHETT:

Page 276

1 Q. From Eastern Health that says this is ER  
 2 positive or ER negative or what have you, you  
 3 take it for what it says unless there's reason  
 4 to doubt the validity of the conclusion?  
 5 MS. PREDHAM:  
 6 A. Yes, that's fair.  
 7 MR. PRITCHETT:  
 8 Q. And the same would apply to a sample, for  
 9 instance, in this case a slide going back,  
 10 that if you're not being told there may be a  
 11 problem with it, you're going to assume  
 12 there's no problem with the end of the process  
 13 that they just handled?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MR. PRITCHETT:  
 17 Q. When you had that discussion with Ms.  
 18 Wegrynowski and this point came up, did you  
 19 contact any counterparts in Western, Central,  
 20 of Grenfell areas about this issue, about this  
 21 concern?  
 22 MS. PREDHAM:  
 23 A. No, I didn't, but I thought Dr. Cook was  
 24 taking it seriously and was going to look into  
 25 that.

Page 277

1 MR. PRITCHETT:  
 2 Q. So leaving that meeting, that was the  
 3 impression you were left with?  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 MR. PRITCHETT:  
 7 Q. But were you ever specifically made aware of  
 8 that communication being made to any of the  
 9 other authorities throughout the province?  
 10 MS. PREDHAM:  
 11 A. No.  
 12 MR. PRITCHETT:  
 13 Q. Thank you. Those are my questions.  
 14 THE COMMISSIONER:  
 15 Q. Thank you. Ms. Newbury, I would normally call  
 16 the afternoon break about ten minutes time.  
 17 It's your call, would you refer to start and  
 18 I'll interrupt you in ten minutes or would you  
 19 prefer to take the break before.  
 20 MS. NEWBURY:  
 21 Q. I'll start.  
 22 MS. HEATHER PREDHAM--EXAMINATION BY MS. JENNIFER NEWBURY  
 23 MS. NEWBURY:  
 24 Q. Good afternoon, Ms. Predham. My name is  
 25 Jennifer Newbury, and I represent the Canadian

Page 278

1 Cancer Society. I have a few questions for  
 2 you this afternoon, starting with, I guess, a  
 3 discussion about the various policies that  
 4 have been in place in Eastern Health and its  
 5 predecessor organizations, in particular,  
 6 Health Care Corporation of St. John's in your  
 7 case, and I just want to speak to this a bit  
 8 more generally, but if you want to see any of  
 9 the policies, we can certainly pull those up.  
 10 There are critical occurrence and incident  
 11 review policies, occurrence reporting  
 12 policies, and adverse events. I think you  
 13 described them as guidelines.  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. And -  
 18 MS. PREDHAM:  
 19 A. Not the adverse events. Disclosure  
 20 guidelines.  
 21 MS. NEWBURY:  
 22 Q. Disclose guidelines, okay.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 MS. NEWBURY:

Page 279

1 Q. And I understood that it was referred to as  
 2 adverse events for the Health Care Corporation  
 3 of St. John's?  
 4 MS. PREDHAM:  
 5 A. Adverse events would be--I think would be  
 6 Eastern Health's terminology.  
 7 MS. NEWBURY:  
 8 Q. Okay. Just, I guess, to clarify that, perhaps  
 9 we could bring up P-0056, please.  
 10 MS. PREDHAM:  
 11 A. Actually, you're right, it's disclosure of  
 12 adverse events.  
 13 MS. NEWBURY:  
 14 Q. Okay, Eastern Health Guidelines, okay.  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 MS. NEWBURY:  
 18 Q. And we'll bring them up, anyway. They'll be  
 19 there just for your reference, and  
 20 subsequently--I guess, those three times of  
 21 policies were in place between 1997 and 2004,  
 22 and in 2005 Eastern Health--2005 and  
 23 subsequent, some other policies came into  
 24 effect, disclosure of adverse events,  
 25 occurrence reporting, and a sentinel events

Page 280

1 policy?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. So they deal generally with the same topics,  
 6 as I understand it, but the wording and some  
 7 of the content may have changed?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. Okay. I'm just wondering what your view is as  
 12 to the applicability of these policies or the  
 13 guidelines to the ER/PR problems subsequent to  
 14 2005?  
 15 MS. PREDHAM:  
 16 A. Well, the ER/PR problem was always seen as a  
 17 sentinel event.  
 18 MS. NEWBURY:  
 19 Q. Okay.  
 20 MS. PREDHAM:  
 21 A. The problem with it, you know, in putting it  
 22 into a policy like that, any of those  
 23 policies, it wasn't black and white because we  
 24 had never seen anything this large or this  
 25 complicated before.

Page 281

1 MS. NEWBURY:  
 2 Q. Okay. So was there doubt as to whether or not  
 3 Eastern Health would have to follow--I guess  
 4 the policy that was in place at the time was  
 5 that of Health Care Corporation of St. John's,  
 6 and that would be, I assume, the critical  
 7 occurrence incident review policy?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. Was there any doubt as to whether or not  
 12 Eastern Health was obligated to follow that  
 13 particular policy?  
 14 MS. PREDHAM:  
 15 A. Oh, no, there was no question that way. It  
 16 was just that this was a very unusual  
 17 occurrence.  
 18 MS. NEWBURY:  
 19 Q. So it wasn't whether or not it should apply,  
 20 it was perhaps the mechanics of how do we go  
 21 about applying it?  
 22 MS. PREDHAM:  
 23 A. Yes, that's fair.  
 24 MS. NEWBURY:  
 25 Q. And is that because of the number of patients

Page 282

1 who were actually involved or caught up in the  
 2 whole issue?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 MS. NEWBURY:  
 6 Q. And would you agree that the absence of a  
 7 multi-patient policy or a policy that clearly  
 8 spells out how we deal as an organization with  
 9 such a large event when there's so many  
 10 patients involved, really is that an issue of  
 11 convenience for the organization that, well,  
 12 we don't have the ability to conveniently  
 13 refer to a policy that says you can do one  
 14 report that applies to, say, 500 patients?  
 15 MS. PREDHAM:  
 16 A. No, it--I guess, as we developed the policies,  
 17 we really hadn't focused in on multi-patient--  
 18 you know, one or two patients probably, but  
 19 nothing of this magnitude, and to even have or  
 20 develop a policy or process on how we were  
 21 going to deal with that -  
 22 MS. NEWBURY:  
 23 Q. Uh-hm.  
 24 MS. PREDHAM:  
 25 A. Requires some different thinking, and we had--

Page 283

1 we have done, actually, a table top exercise  
 2 with a scenario and how we would do that to  
 3 try to figure out, okay, if this happened  
 4 again, if something similar of this magnitude  
 5 happened again, what would be the logistics to  
 6 make it--you know, so we wouldn't go down, we  
 7 wouldn't have the delays, we wouldn't have the  
 8 problems and the questions that we had this  
 9 time, how would we get it to flow better.  
 10 MS. NEWBURY:  
 11 Q. Okay. So would that really be an issue of  
 12 enabling the organization to respond more  
 13 efficiently to the problem and more promptly  
 14 perhaps to the problem?  
 15 MS. PREDHAM:  
 16 A. Oh, definitely.  
 17 MS. NEWBURY:  
 18 Q. Okay, and would you agree that the default  
 19 would be in the absence of such a policy which  
 20 lays it out and enables the organization to  
 21 respond, you know, efficiently, as efficiently  
 22 and as promptly as possible, that the default  
 23 would be that you apply the policy for the  
 24 patients on an individual basis?  
 25 MS. PREDHAM:

Page 284

1 A. Oh, yes, and that was always--the intent was  
 2 that we do that. It was just questions arose  
 3 that we didn't quickly encounter them, and the  
 4 workload as well, and circumstances that we  
 5 were all in, you know, didn't allow for that  
 6 timely resolution of issues.  
 7 MS. NEWBURY:  
 8 Q. So it wasn't ever a situation in your mind  
 9 that the organization could say, well, we  
 10 don't happen to have a policy that deals with  
 11 this situation because there are so many  
 12 patients, so we don't really have a policy to  
 13 go by -  
 14 MS. PREDHAM:  
 15 A. No.  
 16 MS. NEWBURY:  
 17 Q. And we'll just, you know, do it on an ad hoc  
 18 basis?  
 19 MS. PREDHAM:  
 20 A. No.  
 21 MS. NEWBURY:  
 22 Q. And in responding to a similar situation  
 23 today, do I understand your evidence correctly  
 24 that you would feel that the sentinel event  
 25 policy would govern this type of situation?

Page 285

1 MS. PREDHAM:  
 2 A. Yes.  
 3 MS. NEWBURY:  
 4 Q. And again you still would have to try to sort  
 5 out how do we deal with the fact that there's  
 6 so many patients, and how can we deal with  
 7 this as efficiently as possible?  
 8 MS. PREDHAM:  
 9 A. Exactly, yes.  
 10 MS. NEWBURY:  
 11 Q. I just wanted to ask you about the interaction  
 12 between policies that might be in place on a  
 13 department or program basis versus what have  
 14 been described as corporate-wide policies,  
 15 such as those that I've just referred to, and  
 16 in particular there's evidence about--from a  
 17 couple of witnesses now about the corrective  
 18 actions for IHC occurrences, which is a policy  
 19 applicable to the pathology program.  
 20 MS. PREDHAM:  
 21 A. Okay.  
 22 MS. NEWBURY:  
 23 Q. Are you familiar with that particular policy?  
 24 MS. PREDHAM:  
 25 A. No.

Page 286

1 MS. NEWBURY:  
 2 Q. Okay, perhaps I can bring that up. It's P-  
 3 2157 and this is a very large document, so it  
 4 will take a minute or so to bring that up.  
 5 Perhaps I'll give you a little bit of  
 6 background while that exhibit is being is  
 7 brought up. Dr. Morris-Larkin had actually  
 8 referred to this in her evidence and I think  
 9 they were entered through an earlier witness.  
 10 These are policies that she understands to be  
 11 now applicable in the pathology department to  
 12 respond, I think her evidence was that it's  
 13 basically an internal occurrence reporting in  
 14 the lab and it allows the lab to provide  
 15 direct feedback and address the issues in a  
 16 more timely and more direct fashion. Now the  
 17 exact exhibit is on page 177 of that. So this  
 18 is--I think there's actually three pages there  
 19 and if you want to scroll down through that,  
 20 Ms. Predham, and just familiarize yourself  
 21 with the document.  
 22 MS. PREDHAM:  
 23 A. Okay, so this is their internal, when it's a  
 24 quality issue that they're finding with the  
 25 stain and that and they report that and this

Page 287

1 is how they keep track of any issues that they  
 2 had.  
 3 MS. NEWBURY:  
 4 Q. Yes, that's my understanding from her evidence  
 5 as well, and it's a fairly general policy, I  
 6 think if you look at it there.  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. And I was wondering how does this policy fit  
 11 in with the corporate wide policies and in  
 12 particular in a situation if you have  
 13 something that might be considered to be an  
 14 occurrence and they do actually refer to that  
 15 language "occurrence" in this policy, how does  
 16 that impact, I guess, if it does at all upon  
 17 the corporate wide policies about occurrence  
 18 reporting?  
 19 MS. PREDHAM:  
 20 A. Well it fits in quite well because this is  
 21 something internal to the lab, so this is  
 22 meant to track information that they pick up  
 23 in their day to day, as it progresses through  
 24 that. So this would be something that the,  
 25 like and I think the example that Ms. Chaytor

Page 288

1 showed me, that the report isn't signed out  
 2 and the report released outside, at that point  
 3 it would be an occurrence, but this is  
 4 something internal that is identified as an  
 5 issue and is dealt with at that time and is a  
 6 way to trend that. And I think I gave an  
 7 example of the pharmacy that has a very  
 8 extensive one, to double check before it  
 9 leaves, if the person doing the double check  
 10 picks it up, an internal report is done, but  
 11 if it leaves past that person and is  
 12 discovered then, then an occurrence report, a  
 13 corporate wide occurrence report is done.  
 14 MS. NEWBURY:  
 15 Q. And it was my understanding when you were  
 16 giving the evidence about the double check  
 17 system for the pharmacy, is that that's  
 18 something that was, I guess, approved or the  
 19 quality department had some input into that  
 20 type of a program to make sure that it met  
 21 the, I guess the criteria or the objectives of  
 22 quality programs.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 MS. NEWBURY:



Page 289

1 Q. Before that was implemented.  
 2 MS. PREDHAM:  
 3 A. Well not so much that, I mean, they had a  
 4 discussion on, I guess it was when do you fill  
 5 out a occurrence report? What do we need to  
 6 fill out an occurrence report for? They had  
 7 this process in place and they were typing  
 8 that up to do the same kind of review, so that  
 9 they could look at the types of things that  
 10 are being caught before they come out of  
 11 pharmacy to learn is there anything that we  
 12 can do on the front end to fix these? So it  
 13 wasn't that they were getting our approval,  
 14 they were just getting out feedback on, you  
 15 know, as this process goes through.  
 16 MS. NEWBURY:  
 17 Q. Okay. And did you provide similar feedback to  
 18 the pathology department on this policy?  
 19 MS. PREDHAM:  
 20 A. I didn't, no.  
 21 MS. NEWBURY:  
 22 Q. You didn't, okay, and do you know if anyone  
 23 else in your department -  
 24 MS. PREDHAM:  
 25 A. I'm not sure, Ms. Laidley is linked with the

Page 290

1 lab. They do have Ms. Wade works in the lab  
 2 now as a quality person and we do link with  
 3 her.  
 4 MS. NEWBURY:  
 5 Q. Right, uh-hm.  
 6 MS. PREDHAM:  
 7 A. So somebody may have had interaction with her.  
 8 MS. NEWBURY:  
 9 Q. Okay, and are there ever situations that the  
 10 corrective actions and the policies of the  
 11 department or the program would replace what  
 12 goes on in terms of the corporate wide  
 13 policies? Is there ever a dual reporting  
 14 scheme going on?  
 15 MS. PREDHAM:  
 16 A. There may be, I can't think of anything that  
 17 would cover that off, you know, I can't think-  
 18 -there's usually, what has happened is that  
 19 there's a decision, you know, by the program  
 20 that these are the types of things that we  
 21 need to keep track of and as part of this,  
 22 like a quality review, they catch it first and  
 23 then they fix it and that's what it's designed  
 24 to do, that's part of their quality control  
 25 program. And then anything beyond that, would

Page 291

1 be an occurrence, but I don't think that  
 2 there's a disagreement--I can't think of  
 3 anything right now.  
 4 MS. NEWBURY:  
 5 Q. I'm just wondering if there might reach a  
 6 certain level of seriousness or perhaps, you  
 7 know, if a problem is happening, happening  
 8 repeatedly, would there be any obligation to  
 9 pass along that information in accordance with  
 10 the occurrence policies for the corporate wide  
 11 -  
 12 MS. PREDHAM:  
 13 A. There may be, depending on the circumstances,  
 14 I mean, there's always a possibility that  
 15 there could be.  
 16 MS. NEWBURY:  
 17 Q. Right, okay, and you don't know of any sort of  
 18 regular or quarterly or annual reports that  
 19 must be provided from a particular program as  
 20 to how these polices are working, you know,  
 21 here are the statistics that we have?  
 22 MS. PREDHAM:  
 23 A. They have to report to the portfolio  
 24 committees of each of their portfolios, so the  
 25 lab would be reporting to Dr. Howell's

Page 292

1 portfolio committee.  
 2 MS. NEWBURY:  
 3 Q. Right.  
 4 MS. PREDHAM:  
 5 A. So in that, they would have to report on their  
 6 indicators.  
 7 MS. NEWBURY:  
 8 Q. Okay.  
 9 MS. PREDHAM:  
 10 A. So I would anticipate that one of their  
 11 indicators and I haven't seen that, but one of  
 12 their indicators would be, you know, quality--  
 13 whatever, correction action log, forms  
 14 completed, number of actions taken or  
 15 something on that line that they could keep  
 16 track of there.  
 17 MS. NEWBURY:  
 18 Q. So would you anticipate that the report might  
 19 include sort of the numbers or the types of  
 20 problems involved and that if the quality  
 21 department or anyone to whom the program  
 22 reports has any concerns, that they can delve  
 23 into that a bit further?  
 24 MS. PREDHAM:  
 25 A. Yes, each portfolio committee has a

Page 293

1 representative from our department on them.  
 2 So there would be someone there who would see  
 3 these reports.  
 4 THE COMMISSIONER:  
 5 Q. It's about time for that break, wherever it's  
 6 convenient for you, I don't -  
 7 MS. NEWBURY:  
 8 Q. No, this is a good spot.  
 9 THE COMMISSIONER:  
 10 Q. All right then, we'll take the afternoon  
 11 break, but before I do while I have counsel in  
 12 the room, I wanted to give you a heads up on  
 13 Monday. As you probably noticed where the  
 14 evidence for one of our witnesses is scheduled  
 15 for Monday is via video conferencing, it turns  
 16 out when we were doing the schedule, we did  
 17 not anticipate the fact that the time changes  
 18 in England are different than they are in  
 19 Canada, so the good news is that Monday we  
 20 plan to start at 10:30; the bad news is we'll  
 21 end the day an hour later. So, you can adjust  
 22 your plans accordingly. We'll take the  
 23 afternoon break.  
 24 (RECESS)  
 25 THE COMMISSIONER:

Page 294

1 Q. Please be seated. Ms. Newbury.  
 2 MS. NEWBURY:  
 3 Q. Thank you. Commissioner, there are two  
 4 exhibits that I'd ask to enter, C-0275 and C-  
 5 0276.  
 6 THE COMMISSIONER:  
 7 Q. C-0275?  
 8 REGISTRAR:  
 9 Q. No, there's a C-0276 and there a P-03 -  
 10 THE COMMISSIONER:  
 11 Q. The two numbers I have are C-0276 -  
 12 CHAYTOR, Q.C.:  
 13 Q. No, Mr. Crosbie has the other exhibit, he was  
 14 going to enter it.  
 15 THE COMMISSIONER:  
 16 Q. Okay.  
 17 CHAYTOR, Q.C.  
 18 Q. There is another exhibit, C-0275. Has that  
 19 already been -  
 20 REGISTRAR:  
 21 Q. That's already been entered.  
 22 MS. NEWBURY:  
 23 Q. Oh, okay.  
 24 CHAYTOR, Q.C.:  
 25 Q. That's the one we were asking about.

Page 295

1 REGISTRAR:  
 2 Q. (Inaudible).  
 3 THE COMMISSIONER:  
 4 Q. Well, while we're at it, Mr. Crosbie, have you  
 5 requested an exhibit 3468?  
 6 CROSBIE, Q.C.:  
 7 Q. I have.  
 8 THE COMMISSIONER:  
 9 Q. I will enter that at the same time. So, we  
 10 you won't need to make a request later. Thank  
 11 you.  
 12 MS. NEWBURY:  
 13 Q. Thank you.  
 14 EXHIBITS C-0276 AND P-3468 MARKED AND ENTERED.  
 15 MS. NEWBURY:  
 16 Q. Ms. Predham, you gave evidence a few days ago,  
 17 I can't recall which day, that each program  
 18 and department has been encouraged to identify  
 19 occurrences in their area themselves, so,  
 20 what's important to them, it's not necessarily  
 21 something in the routine of their work as an  
 22 occurrence. And I think what you were talking  
 23 about is to try to identify in advance, the  
 24 types of things that might constitute an  
 25 occurrence. So, that when that situation

Page 296

1 arises, the program is familiar with how to  
 2 respond.  
 3 MS. PREDHAM:  
 4 A. Well, the staff would have to know that they  
 5 have to report, if this happens, they need to  
 6 report an occurrence, fill out an occurrence  
 7 report. So, that's the key thing, is that  
 8 this is what the program would like to see  
 9 identified as occurrences.  
 10 MS. NEWBURY:  
 11 Q. So, basically it's an identification issue,  
 12 what constitutes an occurrence.  
 13 MS. PREDHAM:  
 14 A. Exactly.  
 15 MS. NEWBURY:  
 16 Q. And was that exercise ever carried out with  
 17 the laboratory medicine program.  
 18 MS. PREDHAM:  
 19 A. Yes, it would have been over the years. It's  
 20 an ongoing thing. It would have been more  
 21 formally started back in '97, but it would  
 22 have progressed over the time, you know, when  
 23 they filled out occurrences.  
 24 MS. NEWBURY:  
 25 Q. Okay, but would there be sort of a list of

Page 297

1 examples; these are the type of things that  
 2 would constitute an occurrence and if this  
 3 happens, perhaps you can fill out a report.  
 4 MS. PREDHAM:  
 5 A. The programs, each one did it different,  
 6 differently. Some areas did that and some  
 7 areas didn't. They just did it verbally and  
 8 said look, this is the type of thing we'd like  
 9 to have an occurrence on, the manager kept  
 10 track of that.  
 11 MS. NEWBURY:  
 12 Q. Okay. It's not something that's documented  
 13 necessarily.  
 14 MS. PREDHAM:  
 15 A. I wouldn't even begin to know. If it is, I  
 16 wouldn't know where to look for it.  
 17 MS. NEWBURY:  
 18 Q. Okay, thank you. And when discussing the  
 19 quality tool, I think you referred to it as a  
 20 failure modes and effects analysis.  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 MS. NEWBURY:  
 24 Q. You mentioned that there's a process of  
 25 sitting down with the people involved in a

Page 298

1 program, in particular, implementing a new  
 2 process to try to identify particular issues  
 3 or problems that might arise and presumably to  
 4 try to guard against those types of problems.  
 5 MS. PREDHAM:  
 6 A. Exactly.  
 7 MS. NEWBURY:  
 8 Q. And try to develop a process that won't  
 9 attract too many problems.  
 10 MS. PREDHAM:  
 11 A. Well, you're anticipating things that can go  
 12 wrong and trying to put the things in place  
 13 beforehand to prevent those things.  
 14 MS. NEWBURY:  
 15 Q. Okay. So, you try to visualize how this might  
 16 go and where the potential pitfalls. And I  
 17 believe it was your evidence that that type of  
 18 a tool wasn't used when the ER/PR was switched  
 19 to the IHC method because that wasn't in  
 20 vogue, I guess, at the time.  
 21 MS. PREDHAM:  
 22 A. Right.  
 23 MS. NEWBURY:  
 24 Q. It wasn't a tool readily known in the quality  
 25 industry. Was this something that was ever

Page 299

1 done subsequently, just to go back, I guess,  
 2 it's not ideal to do it after the process has  
 3 been implemented, but was there ever an  
 4 attempt to go back and look at that,  
 5 retrospectively, to see where the potential  
 6 pitfalls here, what can we do to change our  
 7 process.  
 8 MS. PREDHAM:  
 9 A. Not that I'm aware of.  
 10 MS. NEWBURY:  
 11 Q. Okay. And based on your evidence about  
 12 identification by departments as to what  
 13 constitutes an occurrence, I assume that it  
 14 would be important for members of the program  
 15 to readily be able to identify an occurrence  
 16 as such.  
 17 MS. PREDHAM:  
 18 A. Oh, definitely.  
 19 MS. NEWBURY:  
 20 Q. Okay. So, it's not just a matter of following  
 21 the procedures, they have to know this is an  
 22 occurrence, we need to file a report.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 MS. NEWBURY:

Page 300

1 Q. And you can have all the elaborate policies in  
 2 the world, but if people don't recognize this  
 3 to be an occurrence, then they're not going to  
 4 be of much benefit to the program.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MS. NEWBURY:  
 8 Q. And it seems, just from a number of witnesses  
 9 giving examples about occurrences, that an  
 10 event such as mislabelling, whether it's  
 11 mislabelling of a specimen or mislabelling of  
 12 a drug, seems to be a readily identifiable  
 13 occurrence. And would you agree with that?  
 14 MS. PREDHAM:  
 15 A. Yes, I would.  
 16 MS. NEWBURY:  
 17 Q. Okay. And I'm not, I guess, I didn't get the  
 18 same impression from the evidence that a  
 19 changed laboratory test result attracts the  
 20 same sort of automatic recognition that this  
 21 is an occurrence. Would you agree with that  
 22 proposition?  
 23 MS. PREDHAM:  
 24 A. At this point in time, I'd say it depends on  
 25 the area of the lab, if we're just talking

Page 301

1 about the lab, we do get occurrences about  
 2 changed results from certain parts of the lab.  
 3 MS. NEWBURY:  
 4 Q. Okay. And what parts of the lab would you say  
 5 fall into that category?  
 6 MS. PREDHAM:  
 7 A. I think it would be biochemistry, but I might  
 8 have the total incorrect name. I haven't gone  
 9 through occurrences from the lab in quite a  
 10 while, but I do know I have seen results that  
 11 have been reported and then subsequently  
 12 changed on occurrence reports, but telling you  
 13 which part of the lab, you know, I think  
 14 biochemistry. That's what's popped in my head  
 15 that I've seen them.  
 16 MS. NEWBURY:  
 17 Q. Okay. And perhaps some of the influencing  
 18 factors as to whether or not a particular  
 19 program or department or person working in the  
 20 area recognizes something to be an occurrence,  
 21 it might depend on whether or not a physician  
 22 was first informed of the initial lab results  
 23 that were ultimately changed.  
 24 MS. PREDHAM:  
 25 A. Well, that would be a critical part because

Page 302

1 again, if it was something that was caught  
 2 before it left the area, it may be seen as,  
 3 you know, with the double checks in it, it may  
 4 be seen as part of that process.  
 5 MS. NEWBURY:  
 6 Q. Okay.  
 7 MS. PREDHAM:  
 8 A. But if it was released, signed out, you know,  
 9 the potential for someone to act on it and  
 10 then discover that it was incorrect, that  
 11 would be an occurrence.  
 12 MS. NEWBURY:  
 13 Q. Okay. But can you say that if a physician was  
 14 not informed of the first set of results, that  
 15 that would definitely not constitute an  
 16 occurrence or is that still a grey area?  
 17 MS. PREDHAM:  
 18 A. I think you would have to look at the  
 19 circumstances there. I wouldn't want to say  
 20 black or white.  
 21 MS. NEWBURY:  
 22 Q. And whether or not a change in result might  
 23 impact the type of treatment that a patient  
 24 would get, whether it was communicated to the  
 25 patient or the treating physician or not,

Page 303

1 would that be a factor influencing whether a  
 2 department or program might consider something  
 3 to be an occurrence or not?  
 4 MS. PREDHAM:  
 5 A. If the lab, you know, you take another part of  
 6 the lab released blood work results and then  
 7 later found it to be incorrect, whether or not  
 8 there was treatment or whatever, I guess they  
 9 would know the importance of the type of test,  
 10 but any kind of test can influence treatment.  
 11 MS. NEWBURY:  
 12 Q. Right.  
 13 MS. PREDHAM:  
 14 A. So, you know, I wouldn't want him  
 15 differentiating because of that because you  
 16 wouldn't know every circumstance that it would  
 17 be that important. So any kind of change,  
 18 like a release that had the potential to be  
 19 acted upon, would be an occurrence.  
 20 MS. NEWBURY:  
 21 Q. What about a change that's not released but  
 22 could have had a very significant impact upon  
 23 patient treatment?  
 24 MS. PREDHAM:  
 25 A. Well that would be something that would come

Page 304

1 up in this program and they'd have to do that.  
 2 You know, there may be and you know, totally  
 3 speculative here, but there may be certain  
 4 things that are, you know, I guess to use the  
 5 example when we look at medication  
 6 occurrences, if we have high alert drugs, so  
 7 we have six categories where we identify high  
 8 alert drugs, so if we had any type of  
 9 occurrence with those, it gets a higher level  
 10 of scrutiny than it does with the other  
 11 medications. So, you know, parts of the lab  
 12 may have that as part of their QA process.  
 13 MS. NEWBURY:  
 14 Q. And is that something that perhaps might be  
 15 advantageous to sit down in advance to try to,  
 16 I guess get down to the details with a  
 17 particular program as to whether or not  
 18 something would constitute an occurrence,  
 19 whether for their own internal laboratory  
 20 purposes or for the corporate wide application  
 21 of policies?  
 22 MS. PREDHAM:  
 23 A. Oh definitely and, you know, occurrence  
 24 reporting is a very challenging area because  
 25 you have frontline staff who are, you know,

Page 305

1 taking the time, they have identified  
 2 something and then they have to be able to  
 3 recognize that as an occurrence and then  
 4 identify the need to fill out an occurrence  
 5 report, but also they have to see that there's  
 6 a purpose of doing this, that there's going to  
 7 be some benefit at the end of the day. And a  
 8 lot of that comes through education, but also  
 9 to relate these are things that happened,  
 10 these are things that have happened because  
 11 you've reported them, and you know, how  
 12 important it is to get them to realize that  
 13 and that's a challenge that's well documented  
 14 in quality literature and one of the key  
 15 things that, with our electronic occurrence  
 16 reporting system is, you know, well a couple  
 17 of the key things, one is the ease of doing  
 18 that. It's also to have prompts of some kind  
 19 in the taxonomy for that area that these are  
 20 the things that your area is reporting, so  
 21 that if you had any question, you'd be able to  
 22 go in and there would be prompts there that  
 23 say these are the types of things that you're  
 24 looking at, but also getting that feedback  
 25 that somebody has gotten this, we've gotten it

Page 306

1 quickly, because those are all the problems  
 2 that we experience with the paper reporting  
 3 system. So, because of the benefits of that  
 4 electronic occurrence reporting system, that's  
 5 why we use it as a tool to change the culture  
 6 because we have to have the culture, everybody  
 7 has to see the impact on patient safety. So  
 8 we're using the occurrence reporting system as  
 9 a tool to influence the culture of the  
 10 organization.  
 11 MS. NEWBURY:  
 12 Q. And one of the advantages of the electronic  
 13 occurrence reporting system is that it does  
 14 provide a bit more information as to what  
 15 would be considered an occurrence or what  
 16 wouldn't be considered an occurrence?  
 17 MS. PREDHAM:  
 18 A. Yes, and it's easily changeable, you know,  
 19 with the paper system when you have it done,  
 20 to even change that piece of paper and, you  
 21 know, you can't adapt it for an area as easily  
 22 as you can an electronic one and the software  
 23 that we've purchased, you know, once they  
 24 identify their area or whatever they're going  
 25 from, they can limit their search of what

Page 307

1 they're doing, so more detail can be in there  
 2 that there could be help--you know, prompts  
 3 there to help them through that as well.  
 4 MS. NEWBURY:  
 5 Q. Okay, and perhaps another couple of factors  
 6 that might influence whether or not a program  
 7 sees something as an occurrence or not would  
 8 be the passage of time between an initial test  
 9 and a retest, whether it was a day or an hour  
 10 or a year.  
 11 MS. PREDHAM:  
 12 A. Well the ability to identify trends like that  
 13 is very important as well.  
 14 MS. NEWBURY:  
 15 Q. And also the reasons for the retest, whether  
 16 someone did it because a specimen was dropped  
 17 on the floor or whether there was another  
 18 broader concern about quality.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MS. NEWBURY:  
 22 Q. And would you agree that the more analysis  
 23 that's done of these types of factors in  
 24 advance, the more readily people might be  
 25 availing of the various occurrence reporting

Page 308

1 policies?  
 2 MS. PREDHAM:  
 3 A. Oh, once you know what's there and once you  
 4 can tell people the type of things that you  
 5 learn from that and it's all, it's all in that  
 6 frontline staff who see that in identifying  
 7 that it's important that I tell people about  
 8 this.  
 9 MS. NEWBURY:  
 10 Q. And in terms of the department, now it has its  
 11 own policy for occurrence, the corrective  
 12 action occurrences, how will that--will that  
 13 be done on an electronic basis as well or will  
 14 that department get the same advantages of the  
 15 electronic occurrence reporting system if they  
 16 now adopt their own internal system that they  
 17 might use more frequently than the corporate  
 18 wide systems?  
 19 MS. PREDHAM:  
 20 A. Right now, we're only in the early stages of  
 21 implementing our big system and the ability to  
 22 sub -  
 23 MS. NEWBURY:  
 24 Q. Until a thousand.  
 25 MS. PREDHAM:

Page 309

1 A. Yeah, hasn't been addressed yet.  
 2 MS. NEWBURY:  
 3 Q. And is that something that you think might be  
 4 worth looking into?  
 5 MS. PREDHAM:  
 6 A. I could be, you know, we'd have to work with  
 7 the areas doing that.  
 8 MS. NEWBURY:  
 9 Q. Ms. Predham, perhaps it will be safe to say  
 10 from your evidence that in the summer of 2005,  
 11 you and other members of the group responding  
 12 to the ER/PR problem were dealing with some  
 13 complex issues?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. And that not all members of the group would be  
 18 well versed in all aspects or all topics of  
 19 that particular area.  
 20 MS. PREDHAM:  
 21 A. Absolutely not.  
 22 MS. NEWBURY:  
 23 Q. So you, yourself, were learning about ER/PR  
 24 for the first time.  
 25 MS. PREDHAM:

Page 310

1 A. Yes.  
 2 MS. NEWBURY:  
 3 Q. And so the techs might be learning information  
 4 that they hadn't known before about what  
 5 oncologists do or vice versa.  
 6 MS. PREDHAM:  
 7 A. Exactly.  
 8 MS. NEWBURY:  
 9 Q. And in addition to the complexity of the  
 10 issues, there's actually a lot of information  
 11 being obtained from various sources, not just  
 12 within Eastern Health, but from Mount Sinai,  
 13 Sloan-Kettering.  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. Mount Sinai about time lines and retesting and  
 18 from Sloan-Kettering about the whole issue  
 19 about lobular cancer and what's expected in  
 20 terms of positivity. Would you agree that  
 21 given the complexity of the information and  
 22 the quantity of information involved, as well  
 23 as your observation that people didn't attend  
 24 all of the meetings all of the time, that that  
 25 might lend itself to mis-communication or

Page 311

1 perhaps some messages not being communicated  
 2 at all to people who ought to know, and that  
 3 it would have been perhaps beneficial to have  
 4 a more comprehensive system for documenting  
 5 all key information?  
 6 MS. PREDHAM:  
 7 A. Oh definitely.  
 8 MS. NEWBURY:  
 9 Q. Okay, and several instances, I believe you, in  
 10 your own handwritten notes when you were  
 11 trying to keep pace with all of that  
 12 information at various meetings, some of your  
 13 notes you had incomplete sentences, perhaps  
 14 that's reflecting the challenge that you had  
 15 of trying to keep up with what was being said.  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 MS. NEWBURY:  
 19 Q. And you gave an example, I think a significant  
 20 example where there was a disagreement between  
 21 you and Mr. Gulliver or a misunderstanding  
 22 between you and Mr. Gulliver as to what  
 23 information you had initially understood  
 24 pertaining to the Ventana equipment and your  
 25 initial understanding that it was ten times

Page 312

1 more sensitive, verses his later clarification  
 2 or denial that he said it and he insisted that  
 3 it was really a matter of the Ventana  
 4 equipment being more consistent.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MS. NEWBURY:  
 8 Q. Do you think it would have been beneficial  
 9 when relying upon people for key information  
 10 to obtain that information in writing?  
 11 MS. PREDHAM:  
 12 A. Yes, or actually you know, over the years when  
 13 I've been involved in this, I, not that I  
 14 don't take people's word for things, but I  
 15 like to have things verified and it never--at  
 16 that time, I didn't realize I hadn't actually  
 17 gotten anything that said, you know, that  
 18 about the Ventana.  
 19 MS. NEWBURY:  
 20 Q. And it may not necessarily be an issue of  
 21 taking someone at their word.  
 22 MS. PREDHAM:  
 23 A. No.  
 24 MS. NEWBURY:  
 25 Q. Whether it was a slip of the tongue or, you

Page 313

1 know -  
 2 MS. PREDHAM:  
 3 A. Exactly.  
 4 MS. NEWBURY:  
 5 Q. - what you actually remembered or heard if you  
 6 were listening to a lot of other complex  
 7 information at the time.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. And perhaps people take more care when they  
 12 write something down that they think is going  
 13 to be relied upon in any significant manner by  
 14 others.  
 15 MS. PREDHAM:  
 16 A. And even having formal minutes that could be  
 17 reviewed by the group, that would be  
 18 beneficial because at least then everybody  
 19 knows what everybody is aware of.  
 20 MS. NEWBURY:  
 21 Q. And they would know if something was  
 22 attributed to them, they can say, no, I didn't  
 23 say that, this is what I -  
 24 MS. PREDHAM:  
 25 A. Exactly.

Page 314

1 MS. NEWBURY:  
 2 Q. If I said it, I apologize, this is what I had  
 3 intended to say or, you know, someone  
 4 misunderstood it, taking down the minutes.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MS. NEWBURY:  
 8 Q. At least then that would give the advantage of  
 9 everyone being aware of all of the same  
 10 information.  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 MS. NEWBURY:  
 14 Q. And would you agree that this would apply when  
 15 information is obtained from external sources,  
 16 whether it's Mount Sinai or Sloan-Kettering or  
 17 the regional health authorities, for that  
 18 matter.  
 19 MS. PREDHAM:  
 20 A. Oh definitely, even when we went across the  
 21 country with our audit, for that matter, you  
 22 know, we spoke to somebody very informally, I  
 23 guess if you want that, and asked some  
 24 questions, it would have been beneficial to  
 25 get that in writing.

Page 315

1 MS. NEWBURY:  
 2 Q. Okay, thank you. Exhibit P-0067 please? Ms.  
 3 Predham, this was a letter that you received,  
 4 I believe in early July or mid July, 2005.  
 5 It's a letter from Dr. Cook to Dr. Williams  
 6 and on page 3 of the report, there are several  
 7 recommendations there from Dr. Cook as to what  
 8 should be done in the immunoperoxidase  
 9 testing. And were you surprised by the  
 10 recommendations that Dr. Cook was making at  
 11 this time?  
 12 MS. PREDHAM:  
 13 A. I don't think I was that surprised, I was more  
 14 concerned by the earlier part of the letter  
 15 and I don't recall, you know, I can remember--  
 16 the one memory I do have when I read them was  
 17 that I was under the impression that external  
 18 proficiency testing was being done and it was  
 19 being done in other parts of pathology, but I  
 20 didn't differentiate between the two parts.  
 21 MS. NEWBURY:  
 22 Q. Right.  
 23 MS. PREDHAM:  
 24 A. But other than that, I was more concerned with  
 25 the rest of the letter.

Page 316

1 MS. NEWBURY:  
 2 Q. With the content of the letter, okay. So  
 3 recommendation one there talks about the  
 4 monitoring--establishing a monitoring program  
 5 immediately and that relates to the external  
 6 proficiency testing, is that the  
 7 recommendation relating to that?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. And what about the recommendation No. 3, which  
 12 recommends training of the technologists in a  
 13 major immuno referral lab that has well  
 14 established quality control and  
 15 troubleshooting programs, did that surprise  
 16 you in the sense that perhaps it might suggest  
 17 that the training beforehand may not have been  
 18 sufficient?  
 19 MS. PREDHAM:  
 20 A. I didn't pick that up at the time.  
 21 MS. NEWBURY:  
 22 Q. Okay, so you weren't reading too much into  
 23 these recommendations at the time?  
 24 MS. PREDHAM:  
 25 A. No, my focus was more on the letter and that,

Page 317

1 you know, I didn't have to worry about it yet,  
 2 but -  
 3 MS. NEWBURY:  
 4 Q. More of that later on, I guess. Exhibit P-  
 5 2949 please? And this is the letter  
 6 containing a draft letter to patients which  
 7 didn't get sent out earlier and you gave some  
 8 evidence about this last week and in  
 9 particular on the first paragraph where it  
 10 states, "Due to improved technology and the  
 11 discovery of inconsistent results, Eastern  
 12 Health has begun retesting a select group of  
 13 patients"--et cetera. And it was your  
 14 evidence that you were hoping at this time  
 15 that you would be able to attribute  
 16 inconsistent results due to the improved  
 17 technology.  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 MS. NEWBURY:  
 21 Q. Would you agree that for Eastern Health to be  
 22 able to attribute inconsistent results to new  
 23 technology that it would essentially have to  
 24 say something to the effect that the lab did  
 25 the best it could with the technology that it

Page 318

1 had until 2004, but it wasn't until 2004 when  
 2 improved technology was obtained by the lab  
 3 that it was then in a position to produce more  
 4 accurate and reliable ER/PR test results.  
 5 MS. PREDHAM:  
 6 A. I don't think I would have said anything like  
 7 that as such, the thought at the time that we  
 8 were hoping was that it was improved  
 9 technology and now we've got a, you know, a  
 10 more intense or more sensitive system which is  
 11 doing the results better.  
 12 MS. NEWBURY:  
 13 Q. But in light of, I guess, the information that  
 14 you had--at this point I think it was  
 15 primarily Dr. Cook's earlier letter that got  
 16 into the specifics.  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. And the recommendations there, even if new  
 21 technology was available as of 2004 when it  
 22 was implemented in the lab, would you have  
 23 thought, looking at Dr. Cook's letter  
 24 generally and the recommendations that the lab  
 25 was doing the best it could with the older

Page 319

1 version of the technology?  
 2 MS. PREDHAM:  
 3 A. No, but I don't think I really absorbed at  
 4 that time those recommendations and the  
 5 implications for that at that time.  
 6 MS. NEWBURY:  
 7 Q. Sure, okay. Now when--I guess shortly after  
 8 this letter was drafted at one of the  
 9 meetings, Mr. Gulliver had clarified to you  
 10 that the Ventana machine was not ten times  
 11 more sensitive than the DAKO equipment, but  
 12 rather the Ventana system was just more  
 13 consistent than DAKO, and you indicated that  
 14 you were a little preoccupied in the balance  
 15 of that meeting -  
 16 MS. PREDHAM:  
 17 A. Yes.  
 18 MS. NEWBURY:  
 19 Q. Just thinking about the implications of that  
 20 clarification. At that point in time, did  
 21 that, I guess, reduce any hope that you might  
 22 have had that you could attribute the  
 23 inconsistent results to the older technology  
 24 or was that another strike against being able  
 25 to say that?

Page 320

1 MS. PREDHAM:  
 2 A. I guess it was another strike, but it was  
 3 also--I think that there was something with  
 4 the consistency of the Ventana which would  
 5 provide better results.  
 6 MS. NEWBURY:  
 7 Q. Uh-hm.  
 8 MS. PREDHAM:  
 9 A. So that was a part there, but it was just the  
 10 fact that, I guess, in my mind I was thinking  
 11 CT scan, MRI, like that type of progression of  
 12 technology, and that was--I had to take that  
 13 out of the picture.  
 14 MS. NEWBURY:  
 15 Q. Uh-hm.  
 16 MS. PREDHAM:  
 17 A. So then I had to rethink the information that  
 18 I had and kind of try to re-centre then around  
 19 that without that part.  
 20 MS. NEWBURY:  
 21 Q. When you did the quality review of the IHC  
 22 laboratory in early August, 2005, and learned  
 23 at that time that the types of documents that  
 24 you had expected didn't exist, that the key  
 25 quality assurance activities that was being



Page 321

1 used was the technologist reliance upon  
 2 feedback form pathologists -  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 MS. NEWBURY:  
 6 Q. And when you later learned that the  
 7 technologists had concerns about communication  
 8 that they had with the pathologists -  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 MS. NEWBURY:  
 12 Q. And I believe you later learned that the  
 13 pathologists weren't aware that they were the  
 14 key quality assurance tool.  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 MS. NEWBURY:  
 18 Q. When you learned all of that, did that further  
 19 dash any hopes that you would have of being  
 20 able to rely upon the implementation of new  
 21 improved technology to explain the  
 22 inconsistent results?  
 23 MS. PREDHAM:  
 24 A. It was a factor, but it was getting smaller  
 25 all the time.

Page 322

1 MS. NEWBURY:  
 2 Q. Okay. And in light of those types of problems  
 3 that you learned in the lab in your review, as  
 4 well as the information from Mr. Gulliver  
 5 about the Ventana equipment and the fact that  
 6 it was just more consistent rather than more  
 7 sensitive, as well as Dr. Cook's letter and  
 8 his recommendations from mid May or late May,  
 9 2005, at that point in time how realistic do  
 10 you think it would have been to expect that  
 11 you could essentially say that the lab was  
 12 doing the best they could with the older  
 13 technology?  
 14 MS. PREDHAM:  
 15 A. Well, we couldn't really say that because we  
 16 couldn't prove that. Even if we were doing  
 17 the best we could, even if we followed  
 18 everything perfectly and did everything, we  
 19 had no proof that we did. So there were  
 20 enough questions that when we asked, you know,  
 21 why this or why that, there was enough  
 22 questions and doubt there that you couldn't  
 23 say that.  
 24 MS. NEWBURY:  
 25 Q. In your experience and your various roles in

Page 323

1 quality over the years, if you--if there isn't  
 2 a proof of all of these types of procedures in  
 3 place, the documentation that you might have  
 4 expected, the quality assurance programs in  
 5 place, how realistic is it that they were  
 6 doing everything the way they should have  
 7 been?  
 8 MS. PREDHAM:  
 9 A. I've had experience over the time that people  
 10 do that without the lack of documentation, and  
 11 I gave a--I told about another incident that  
 12 we had where we thought there was a cross  
 13 contamination and we were able to do an  
 14 observation on it. There was little or no  
 15 documentation, which was one of the  
 16 suggestions that we had, and there were a few  
 17 small breaks in practice that could be  
 18 improved, but nothing really--nothing that  
 19 really stood out, but the practice was very  
 20 good and they'd been doing it for a period of  
 21 time and they were following all the processes  
 22 as they went through because we could watch  
 23 them do that, and confirm that, but if we  
 24 hadn't been able to do that genetic testing on  
 25 the virus, we would have put it down to we

Page 324

1 weren't able to do this stuff. We would have,  
 2 you know, felt that we didn't have any proof  
 3 there that they were doing that well, but they  
 4 were still doing a very good job in that, but  
 5 they didn't have any documentation to support  
 6 that to--for their accountability of what they  
 7 were doing.  
 8 MS. NEWBURY:  
 9 Q. And you indicated that the individuals who  
 10 were involved in that--that was just one  
 11 instance, it wasn't a collection of potential  
 12 problems, it was just one instance of cross  
 13 contamination?  
 14 MS. PREDHAM:  
 15 A. Well, it was one instance, but we had several  
 16 patients involved.  
 17 MS. NEWBURY:  
 18 Q. And in that instance, were the people involved  
 19 able to clearly communicate what their  
 20 procedures and protocols were?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 MS. NEWBURY:  
 24 Q. And precise, and there was no room for -  
 25 MS. PREDHAM:

Page 325

1 A. No.  
 2 MS. NEWBURY:  
 3 Q. Doubt about any detail.  
 4 MS. PREDHAM:  
 5 A. No.  
 6 MS. NEWBURY:  
 7 Q. And did you get the same assurances when you  
 8 were discussing doing your review of the lab  
 9 with the technologists?  
 10 MS. PREDHAM:  
 11 A. Well, it was a bit difficult because the  
 12 equipment wasn't there. We couldn't go  
 13 through the actual process that they were  
 14 using. I couldn't observe them do that on the  
 15 old machine.  
 16 MS. NEWBURY:  
 17 Q. Uh-hm.  
 18 MS. PREDHAM:  
 19 A. They were quite knowledgeable with the new  
 20 one, but I didn't have anything about the old  
 21 one.  
 22 MS. NEWBURY:  
 23 Q. Was there any thought to attempting to locate  
 24 another machine just to perhaps ask them how  
 25 to do it or perhaps get a lab manual to

Page 326

1 refresh the memory of the technologists?  
 2 MS. PREDHAM:  
 3 A. No, not at that point.  
 4 MS. NEWBURY:  
 5 Q. Ms. Predham, you spoke last week about the  
 6 80/20 rule and your understanding of its  
 7 application in the quality field.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. And it was your observation that at Eastern  
 12 Health, 95 percent of the time a problem is  
 13 due to the way things are done, not the people  
 14 actually doing it?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 MS. NEWBURY:  
 18 Q. And the general rule, I think you stated, was  
 19 either 80 or 85 percent of the time if they're  
 20 having a problem, it's due to the way things  
 21 are done, not the people actually doing it?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 MS. NEWBURY:  
 25 Q. And that's a fundamental philosophy behind

Page 327

1 quality improvement?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. And would you say that the way things are done  
 6 would typically involve a number of factors?  
 7 MS. PREDHAM:  
 8 A. Oh, definitely, and also the way things are  
 9 done also includes the supports the  
 10 organization has put in around it.  
 11 MS. NEWBURY:  
 12 Q. Uh-hm.  
 13 MS. PREDHAM:  
 14 A. So if somebody is doing a procedure and  
 15 they're doing a procedure by wrote (phonetic),  
 16 time to time, what reminders, what parameters,  
 17 what double checks are in place, if there's  
 18 known areas where you can make a mistake, so  
 19 that's part of the way that things are done,  
 20 what supports are there by the organization to  
 21 prevent errors.  
 22 MS. NEWBURY:  
 23 Q. Okay, and it wouldn't be a matter of just  
 24 pointing to one particular step that was  
 25 missed along the way?

Page 328

1 MS. PREDHAM:  
 2 A. I mean, it could be. Given the circumstances,  
 3 it could be there may be one step.  
 4 MS. NEWBURY:  
 5 Q. But in your experience, would it be typically  
 6 more than one step?  
 7 MS. PREDHAM:  
 8 A. Typically--well, take the swiss cheese model,  
 9 that there's a multitude of factors, and  
 10 unfortunately with that model, it only takes  
 11 one to stop something.  
 12 MS. NEWBURY:  
 13 Q. Sure. So it is your experience then that it's  
 14 more of a swiss cheese -  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 MS. NEWBURY:  
 18 Q. Occurrence or observation that you make up to  
 19 95 percent of the time?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 MS. NEWBURY:  
 23 Q. And -  
 24 THE COMMISSIONER:  
 25 Q. Sorry to interrupt, but there's something I'm

Page 329

1 not getting, so we might as well resolve it  
 2 now. When you say 95 percent is due to the  
 3 way things are done, and then you went on to  
 4 add about institutional supports, then you are  
 5 attributing to the cause of a problem, the  
 6 absence of features which would catch the  
 7 problem?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 THE COMMISSIONER:  
 11 Q. So it's not only was a, b, c, d, e, done  
 12 correctly because if it's done correctly,  
 13 there is no problem.  
 14 MS. PREDHAM:  
 15 A. Right.  
 16 THE COMMISSIONER:  
 17 Q. But it's whether or not there are in place  
 18 other features which enable you to determine  
 19 whether a, b, c, d, and e were done correctly?  
 20 MS. PREDHAM:  
 21 A. Yes. One of the premises of the whole patient  
 22 safety movement is that you have to understand  
 23 that people will make mistakes, and especially  
 24 in complex environments like a hospital,  
 25 they're more likely to make mistakes. So the

Page 330

1 organization has an onus then to put in those  
 2 double checks to catch known mistakes, and the  
 3 other component of it is that if something  
 4 does go wrong, what is the recovery processes  
 5 in place. So if something happens, and  
 6 something goes wrong, how do people react and  
 7 do they know how to react. So if the discover  
 8 that there's--you know, which is like  
 9 occurrence reporting or like quality control,  
 10 but it may be a bit more specific in certain  
 11 areas.  
 12 MS. NEWBURY:  
 13 Q. Uh-hm.  
 14 MS. PREDHAM:  
 15 A. If they discover something happened, how do  
 16 they quickly recover from that.  
 17 MS. NEWBURY:  
 18 Q. So it's a response to the problem to hopefully  
 19 mitigate or avoid potential damages?  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 MS. NEWBURY:  
 23 Q. And over what period of time did you make the  
 24 observations that Eastern Health 95 percent of  
 25 the time it's the way things are done?

Page 331

1 MS. PREDHAM:  
 2 A. That would be from '96 on up. I know when I  
 3 finally saw the swiss cheese model, it  
 4 resonated with me because I had seen it  
 5 happen, I had seen it occur numerous times  
 6 before I had seen the model.  
 7 MS. NEWBURY:  
 8 Q. So you didn't need a big description as to  
 9 what that meant?  
 10 MS. PREDHAM:  
 11 A. No.  
 12 MS. NEWBURY:  
 13 Q. And in handling disclosure over the years when  
 14 problems arise, has it been your observation  
 15 that patients are not interested in hearing  
 16 the detail about problems when they are due to  
 17 the way things are done?  
 18 MS. PREDHAM:  
 19 A. I don't know if they're not interested. Some  
 20 people are interested in a great level of  
 21 detail, and some people just want a general  
 22 gist of what happened, some people want  
 23 someone to blame.  
 24 MS. NEWBURY:  
 25 Q. Uh-hm.

Page 332

1 MS. PREDHAM:  
 2 A. And they want us to blame somebody, and  
 3 sometimes they perfectly understand that  
 4 everybody is human and mistakes happen.  
 5 MS. NEWBURY:  
 6 Q. Uh-hm.  
 7 MS. PREDHAM:  
 8 A. So it's very, very different. I'd say each  
 9 time it's been different.  
 10 MS. NEWBURY:  
 11 Q. And I guess I asked the question because it  
 12 was your evidence, I think, over the last  
 13 couple of days that when advising patients,  
 14 particularly those that were confirmed  
 15 negatives, of the results of the retesting,  
 16 and addressing the issue of the cause of the  
 17 problem, the patients were not--they were  
 18 really only interested in finding out the one  
 19 cause of the problem, and if there wasn't only  
 20 one cause, they were not particularly  
 21 interested in finding more of the detail?  
 22 MS. PREDHAM:  
 23 A. They didn't ask me the specific detail.  
 24 MS. NEWBURY:  
 25 Q. Okay, and is that consistent with your

Page 333

1 experience over the years since 1996, that  
 2 when you have these sort of more systemic type  
 3 problems that occur, in 95 percent of the time  
 4 that patients are equally not interested, or  
 5 that's your understanding that they don't  
 6 pressure the questions?  
 7 MS. PREDHAM:  
 8 A. Sometimes. You know, I've had--I've disclosed  
 9 information to one lady about her father who  
 10 died, and she didn't want to know the  
 11 circumstances that led to the ultimate  
 12 circumstance that led to his death, she just  
 13 wanted to know about that circumstance, the  
 14 actual final thing. I guess, the final hole  
 15 in the swiss cheese, and--but she had no  
 16 interest in the rest of it.  
 17 MS. NEWBURY:  
 18 Q. Okay.  
 19 MS. PREDHAM:  
 20 A. But I had another one who wanted to know every  
 21 detail along the steps, what contributed to  
 22 it, what happened, what--you know.  
 23 MS. NEWBURY:  
 24 Q. So over the years then in other reports to  
 25 patients or disclosure of problems to

Page 334

1 patients, you've had a variety of experiences  
 2 with the patients?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 MS. NEWBURY:  
 6 Q. But you can't say the same for the disclosure  
 7 that you've been making regarding the ER/PR  
 8 problem, that there hasn't been the same  
 9 variety of interest?  
 10 MS. PREDHAM:  
 11 A. Well, no, but I also--it's a different  
 12 circumstance because I wasn't--in all the ones  
 13 that I've been involved before, there's been a  
 14 very serious adverse outcome, you know,  
 15 there's been a death or a debilitation, or  
 16 something on that level, and I guess maybe  
 17 that makes it a little bit different than, you  
 18 know, I was telling people that the results--  
 19 these were your results, and these are your  
 20 results now. So it may be a different level.  
 21 MS. NEWBURY:  
 22 Q. So you're attributing it to the fact that you  
 23 were in a position that you were telling  
 24 patients that they've been confirmed negative?  
 25 MS. PREDHAM:

Page 335

1 A. Yes, and I really hadn't thought about it  
 2 before now, but maybe that's a contributing  
 3 factor.  
 4 MS. NEWBURY:  
 5 Q. And you were in some other meetings, though.  
 6 I think you attended at least one meeting with  
 7 patients where that wasn't the case?  
 8 MS. PREDHAM:  
 9 A. No, Ms. Parsons did.  
 10 MS. NEWBURY:  
 11 Q. Okay, thank you. Ms. Predham, do you perceive  
 12 it to be a good thing that 95 percent of the  
 13 time the problem is due to the way things are  
 14 done as opposed to a particular individual  
 15 being a cause of a problem?  
 16 MS. PREDHAM:  
 17 A. I don't think that's a good thing. I think  
 18 that's--you know, if it was the other way  
 19 around and we had bad people working for us,  
 20 that may be easier to deal with because you  
 21 could deal with the bad person and then move  
 22 on. It makes it more complex when it's a  
 23 system issue.  
 24 MS. NEWBURY:  
 25 Q. Because you have more holes to patch up?

Page 336

1 MS. PREDHAM:  
 2 A. Yes, and it's harder to get a handle on as  
 3 well.  
 4 MS. NEWBURY:  
 5 Q. Okay, and has it ever been considered that the  
 6 way things are done are sometimes due to  
 7 choices by individuals working in the system?  
 8 MS. PREDHAM:  
 9 A. Well, that's one of the--when you're  
 10 investigating these, there's various tools  
 11 that you can get that you go through to help  
 12 you determine if it is an individual issue or  
 13 if it's a system issue.  
 14 MS. NEWBURY:  
 15 Q. Uh-hm.  
 16 MS. PREDHAM:  
 17 A. And of those, you know, you'd look at a  
 18 substitution test. So would somebody with the  
 19 same education, the same practical experience,  
 20 in the same circumstance make the same  
 21 decisions. That type of thing.  
 22 MS. NEWBURY:  
 23 Q. Uh-hm.  
 24 MS. PREDHAM:  
 25 A. So, you know, yes, it could be--it could be a

Page 337

1 decision thing, but that doesn't mean that  
 2 it's an individual thing, it may be just the  
 3 circumstances.  
 4 MS. NEWBURY:  
 5 Q. Right, it might have been a reasonable  
 6 decision, but one that was not -  
 7 MS. PREDHAM:  
 8 A. And it could be related to--you know, say,  
 9 there was a policy change and the organization  
 10 didn't do a good job in educating about the  
 11 policy change.  
 12 MS. NEWBURY:  
 13 Q. Uh-hm.  
 14 MS. PREDHAM:  
 15 A. So the staff member made a wrong decision  
 16 based on lack of knowledge.  
 17 MS. NEWBURY:  
 18 Q. Uh-hm.  
 19 MS. PREDHAM:  
 20 A. So then that's--you know, that's the type of  
 21 thing.  
 22 MS. NEWBURY:  
 23 Q. Yeah, not to say that all decisions that might  
 24 be the fault of an individual choice or action  
 25 somehow is a terrible thing necessarily.

Page 338

1 MS. PREDHAM:  
 2 A. Yes.  
 3 MS. NEWBURY:  
 4 Q. It's just it may be, like you said, due to the  
 5 level of education or what might have perhaps  
 6 been known in the health care industry at the  
 7 time?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. But would you agree that the way things are  
 12 done basically arise from a variety of  
 13 decisions made by individuals or the  
 14 organization? You could have a process that  
 15 was put in place after an intensive failure  
 16 modes and effects analysis session, or you  
 17 could at the other extreme have a process put  
 18 in place that was the result of very little  
 19 time, effort, or resources on developing and  
 20 documenting, for example, standard operating  
 21 procedures?  
 22 MS. PREDHAM:  
 23 A. Uh-hm.  
 24 MS. NEWBURY:  
 25 Q. So there's a whole gamut there of, you know,

Page 339

1 why things are done in a particular way -  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. By an organization, and some might have been,  
 6 you know, with great effort to hopefully avoid  
 7 any problems, but unsuccessful?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. And others might have been as a result of very  
 12 little effort to avoid and guard against  
 13 particular types of problems?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. And in retrospect and hindsight looking at all  
 18 that has happened over the last few years, do  
 19 you still really believe that patients were  
 20 only interested in finding out just one cause  
 21 of the problems for ER/PR testing and they  
 22 would not be interested in more detail?  
 23 MS. PREDHAM:  
 24 A. No, no, and I don't think -  
 25 MS. NEWBURY:

Page 340

1 Q. Sorry, I must have misunderstood.  
 2 MS. PREDHAM:  
 3 A. Sorry, if I gave that impression.  
 4 MS. NEWBURY:  
 5 Q. Okay.  
 6 MS. PREDHAM:  
 7 A. But I do know that several asked me  
 8 specifically, you know, what happened, and  
 9 when I went into discussion that there was a  
 10 multitude of things, or that it appears to be  
 11 a multitude of things, you know, they weren't  
 12 really pushing on, well, what are they, they  
 13 didn't specifically ask me what they were.  
 14 MS. NEWBURY:  
 15 Q. And did you ever consider that a patient or  
 16 family hearing that sort of an explanation  
 17 might be deterred from pursuing the matter  
 18 further or perhaps didn't have enough context  
 19 in which to press for more information?  
 20 MS. PREDHAM:  
 21 A. No, it didn't occur to me.  
 22 MS. NEWBURY:  
 23 Q. And in light of, I guess, a couple of  
 24 circumstances that have, I guess, come to  
 25 light since your communications with patients,

Page 341

1 first of all we have the ethics consultation  
 2 report, Mr. Singleton. Perhaps I could bring  
 3 that up just for your reference, P-0783,  
 4 please, and you were shown this, I believe,  
 5 yesterday, and in his report he has stated  
 6 here by the cursor, "There were no mistakes or  
 7 technical errors at the root of this problem",  
 8 and notwithstanding Mr. Singleton's direct  
 9 communication with several individuals who had  
 10 knowledge of the particular problem, he still,  
 11 I guess, left that session and drew a  
 12 conclusion which he wrote in the report that  
 13 there were no mistakes or technical errors  
 14 there, and we also have evidence of Joan Dawe,  
 15 and I'm not sure if you're familiar with her  
 16 evidence, that--again she learned about the  
 17 problem first in September of 2005 at a  
 18 meeting, and I think that was following a  
 19 presentation--a verbal presentation from Dr.  
 20 Williams that lasted about an hour. Are you  
 21 familiar with how she learned of the ER/PR  
 22 problem?  
 23 MS. PREDHAM:  
 24 A. Through this process.  
 25 MS. NEWBURY:

Page 342

1 Q. Okay, and she had subsequent updates as well  
 2 about the problem, but she was under the  
 3 impression, for a considerable period of time,  
 4 that new technology was a major contributing  
 5 factor to the circumstances surrounding the  
 6 testing and she expressed some disappointment  
 7 about not having been advised, at least at a  
 8 high level, about the general nature of the  
 9 quality and organizational issues described by  
 10 Dr. Banerjee and Ms. Wegrynowski in their  
 11 external review reports, and I'm just  
 12 wondering, given that Mr. Singleton and Ms.  
 13 Dawe had lengthy careers affiliated with the  
 14 health care industry and direct access to  
 15 knowledgeable persons within Eastern Health  
 16 and in fact, had direct communication with  
 17 them on these particular issues, were  
 18 apparently themselves not able to ask the  
 19 appropriate questions to elicit a better  
 20 understanding of what caused the ER/PR  
 21 problem, and in light of that information, in  
 22 hindsight, do you think that perhaps the  
 23 patients might have also been in the same  
 24 position that they just may not have known  
 25 which questions to ask to elicit more detailed

Page 343

1 information?  
 2 MS. PREDHAM:  
 3 A. They certainly could have.  
 4 MS. NEWBURY:  
 5 Q. Okay, and would you think that a patient would  
 6 be in any better position than either Mr.  
 7 Singleton or Ms. Dawe to elicit that  
 8 information?  
 9 MS. PREDHAM:  
 10 A. No, but now every patient that we spoke to, we  
 11 left our name and number if they had any  
 12 questions, and some did call back and ask  
 13 questions. But you know, you're right. I  
 14 mean, it was--we identified that it was a  
 15 phone call out of the blue, you know, and  
 16 telling them this information and it was  
 17 there. I know, in reviewing documents, that I  
 18 had made the plan to write them after. That  
 19 had been a discussion of a plan, but again,  
 20 the way that we did this caused problems and  
 21 caused things to be overlooked and that was  
 22 one of the things that got overlooked.  
 23 MS. NEWBURY:  
 24 Q. Did you ever advise a patient on the issue of  
 25 causation that you were aware of several

Page 344

1 factors that could have contributed to their  
 2 particular problem or that contributed to the  
 3 problems generally and come out and offered to  
 4 share that information with the patients?  
 5 MS. PREDHAM:  
 6 A. I don't think I would have worded it that way.  
 7 MS. NEWBURY:  
 8 Q. Ms. Predham, on the role of Nancy Parsons as a  
 9 patient relations officer and a patient  
 10 contact, do you think it would have been  
 11 appropriate for Ms. Parsons to advise patients  
 12 whose results had changed, and she was aware  
 13 of the change, that the retest results were  
 14 back from Mount Sinai, a panel would be  
 15 reviewing her file to see if any changes of  
 16 treatment were necessary or just to simply  
 17 advise them that a panel review would be  
 18 necessary or a physician review would be  
 19 necessary and that a physician would  
 20 ultimately be in touch with her?  
 21 MS. PREDHAM:  
 22 A. Maybe. At the time when we talked about it  
 23 and I sought direction, there was no  
 24 recommendation to change it to anything else  
 25 and it was--and that's the way it was

Page 345

1 responded to.

2 MS. NEWBURY:

3 Q. So you understood that Ms. Parsons was telling

4 such patients who called that she didn't have

5 any information to give them?

6 MS. PREDHAM:

7 A. Yes.

8 MS. NEWBURY:

9 Q. And were you aware that some oncologists, upon

10 receiving a panel letter for which there was

11 no treatment change recommended, that some of

12 those would not immediately communicate this

13 information to the patient, but rather would

14 wait until the next regular appointment to

15 make this communication?

16 MS. PREDHAM:

17 A. I think we discovered that in the verification

18 process.

19 MS. NEWBURY:

20 Q. And when was that?

21 MS. PREDHAM:

22 A. That was in 2008, but I also had that one

23 incident in 2006, the fall of 2006, I think.

24 MS. NEWBURY:

25 Q. Okay, and we've had evidence here that this

Page 346

1 was Dr. Siddiqui's approach in handling those

2 cases.

3 MS. PREDHAM:

4 A. Oh, no, I was not aware of that.

5 MS. NEWBURY:

6 Q. Okay, and Dr. McCarthy actually testified that

7 this approach was given at the direction of

8 Dr. Laing, and perhaps it would be helpful to

9 bring up her evidence, September 19th, page

10 391.

11 THE COMMISSIONER:

12 Q. While that's coming up, you said that, in

13 response to a question by, I think, Ms.

14 Newbury, regarding Nancy Parsons and her

15 method of dealing with inquiries, you said you

16 sought direction?

17 MS. PREDHAM:

18 A. Yes. Well, we had this concern when patients

19 called. Now, I mean, as far as I understood,

20 there was not a lot. There was only, you

21 know, a few patients that called that actually

22 the results were back and she was put in that

23 position.

24 THE COMMISSIONER:

25 Q. Um-hm.

Page 347

1 MS. PREDHAM:

2 A. And it was--you know, it was very concerning,

3 especially to Ms. Parsons, because she had to

4 speak to them. So she asked--so we asked Dr.

5 Williams and Dr. Laing if they could, you

6 know, what would be the best way to approach

7 that and they just said, well, you know, do

8 that, get them panelled as quickly as

9 possible.

10 THE COMMISSIONER:

11 Q. So it was the advice of Dr. Laing and Dr.

12 Williams to continue the method which has been

13 described to us by Ms. Parsons?

14 MS. PREDHAM:

15 A. Yes.

16 THE COMMISSIONER:

17 Q. And put them on the list for panelling as

18 quickly as you could?

19 MS. PREDHAM:

20 A. Yes.

21 THE COMMISSIONER:

22 Q. All right, thank you.

23 MS. NEWBURY:

24 Q. Now on page 391, I'm going to read this out.

25 The question that I asked Dr. McCarthy, "I'm

Page 348

1 just wondering, upon receipt of the panel

2 letters, what was your practice with the

3 different types of letters? And I understand

4 some might have recommended a treatment

5 change. Some may have recommended no change

6 of treatment. Others, you may have already

7 dealt with, and in each of those situations,

8 how did you handle the situation when you

9 received the panel letter?" And Dr. McCarthy

10 replied, "well, Dr. Laing gave us, the

11 oncologists, specific recommendations. If

12 there was a treatment change, you were to

13 contact the patient as soon as possible and

14 advise the patient of the treatment change.

15 If there was no treatment change, so to give

16 you the example of ER"--and I think this might

17 be confused here, "ER positive 90 percent,

18 where they already got Tamoxifen, now they

19 were 30 and 90. She felt and agreed that the

20 next available clinic appointment would be

21 adequate to explain that to the patient, since

22 the treatment did not change."

23 And then I questioned Dr. McCarthy "okay,

24 and I understand from earlier evidence from

25 Dr. Siddiqui that the appointments typically

Page 349

1 for a patient who was being followed would be  
 2 perhaps every six months and it might  
 3 alternate between a radiation oncologist and a  
 4 medical oncologist" and Dr. McCarthy replies  
 5 "or even yearly."  
 6 And then I questioned her again "or even  
 7 yearly, okay, and in some cases, where there  
 8 was no recommended change of treatment, was it  
 9 your understanding that if they didn't have an  
 10 appointment for three months down the road or  
 11 eight months down the road, that the  
 12 information would be relayed to that patient  
 13 at that next appointment?" and her answer was  
 14 yes. And my question, "and was that your  
 15 understanding to be the protocol according to  
 16 Dr. Laing?" Her answer was yes.  
 17 And on the next page, "was that relayed  
 18 to you in a meeting or was there any written  
 19 record of that?" Dr. McCarthy replied, "there  
 20 was no written. We discussed this during the  
 21 panel itself, and as well, we discussed it at  
 22 our oncology meetings after rounds so that the  
 23 other oncologists would be in the loop." And  
 24 then I questioned her "so it was your  
 25 understanding that your colleagues all would

Page 350

1 have understood that to be the direction of  
 2 all?" and her answer was yes.  
 3 And on the next page, 395, in the right-  
 4 hand column, I questioned her again. "I guess  
 5 the concern or the question that I have now--  
 6 is now would a patient whose results had  
 7 changed, albeit there would be no recommended  
 8 change of treatment, how would these patients  
 9 know or first learn that there would be no  
 10 change of treatment for them?" and Dr.  
 11 McCarthy replied "at their next clinic visit."  
 12 My question "was there any concern that there  
 13 are a lot of patients out there who are  
 14 anxious to get the information and they might  
 15 be, you know, quite worried about knowing what  
 16 impact the ER/PR retesting would have upon  
 17 them?" and Dr. McCarthy replied "any patients  
 18 who called in who inquired, who wanted to  
 19 speak with us, we dealt with those. We spoke  
 20 with them. We met with them at their  
 21 request."  
 22 Then I asked, "but they would not  
 23 necessarily know, you know, where the process  
 24 was, whether or not the results were available  
 25 at that time." And Dr. McCarthy replied

Page 351

1 "well, there was a hotline that they would  
 2 call and Ms. Parsons would advise them of  
 3 that." And then I asked "was there ever any  
 4 discussion about adopting another approach in  
 5 terms of those patients who had a change in  
 6 result but no change of treatment?" and her  
 7 reply was "not that I recall."  
 8 So it would appear that Dr. McCarthy  
 9 thought that a patient who is particularly  
 10 anxious might call the hotline and given some  
 11 indication that there was a change of  
 12 treatment and perhaps they could call the  
 13 physician and make an appointment and get the  
 14 changes there.  
 15 MS. PREDHAM:  
 16 A. Well, in that circumstance, they would have  
 17 already been panelled.  
 18 MS. NEWBURY:  
 19 Q. Right.  
 20 MS. PREDHAM:  
 21 A. I think Ms. Parsons was referring only to  
 22 people whose results came back and they had  
 23 not been panelled yet.  
 24 MS. NEWBURY:  
 25 Q. But I think Dr. McCarthy there, the focus of

Page 352

1 the question was what about the anxiety of  
 2 those patients who know generally, from the  
 3 media, that there is a retesting program  
 4 taking place. They're anxiously awaiting for  
 5 their results. Those patients are panelled,  
 6 but some of those patients do not have a  
 7 recommended treatment change. Now the  
 8 oncologists, according to what Dr. McCarthy is  
 9 saying, and consistent with what Dr. Siddiqui  
 10 had adopted as his approach, would be only  
 11 those patients who had a change of treatment  
 12 would be contacted immediately. Others might  
 13 have to wait for six months or perhaps even a  
 14 year before they would be told "yes, there was  
 15 a change of your results, but there was no  
 16 change of treatment," and the only other  
 17 possibility that Dr. McCarthy would have as to  
 18 how they might otherwise learn of their  
 19 results earlier would be if they happen to  
 20 call the oncologist and set up an appointment,  
 21 in which case they would accommodate that  
 22 patient's request. But of course, the concern  
 23 I pointed out to her was how would they know  
 24 when to call. Do they call weekly? Do they  
 25 call monthly? They have no idea where they



Page 353

1 are in the system. And the other possibility  
 2 that she suggested is that they could call the  
 3 hotline and perhaps find out a bit more  
 4 information as to whether or not the results  
 5 are back, but of course, according to Nancy  
 6 Parsons, they would not be told. They would  
 7 not even be told that their results are  
 8 available and that a panel would be looking at  
 9 it.  
 10 MS. PREDHAM:  
 11 A. Well, in that circumstance, the fact that the  
 12 oncologists were told to wait for the next  
 13 clinic visit, I'm very surprised at, and  
 14 during the verification process, it didn't  
 15 strike me that there were a lot of people who  
 16 were waiting--you know, who were told with a  
 17 discrepancy time by the oncologists. But Ms.  
 18 Parsons' concern and the situation that we  
 19 were talking about were solely the people  
 20 whose results were back and had not been  
 21 panelled. That's the only ones that she had  
 22 that concern with saying that. The ones that  
 23 were panelled, she would--if they had not  
 24 known and they were panelled, then Ms. Parsons  
 25 would just say "I'll have to check into it"

Page 354

1 and then would track down the physician as Dr.  
 2 McCarthy said, and arrange an appointment time  
 3 to meet with them. The only ones that I'm  
 4 aware that Ms. Parsons ever said that there  
 5 was "nothing new to tell you" were the ones  
 6 whose results had converted and they had not  
 7 been panelled yet.  
 8 MS. NEWBURY:  
 9 Q. Okay. So your understanding that she would  
 10 make some efforts to contact the physician if,  
 11 in fact, she was aware that the patient had  
 12 been panelled?  
 13 MS. PREDHAM:  
 14 A. Oh yes, definitely.  
 15 MS. NEWBURY:  
 16 Q. And how would Ms. Parsons know--what sort of  
 17 time frame was there for Ms. Parsons learning  
 18 about the fact that paneling had taken place?  
 19 MS. PREDHAM:  
 20 A. Well, you know, if she had--she had a list of  
 21 all the patients there, but also I was only  
 22 down the hall for her to ask and we talked  
 23 about patients who called in numerous times.  
 24 MS. NEWBURY:  
 25 Q. And so were you ever aware that this was

Page 355

1 actually the approach that had been adopted,  
 2 almost as an official approach, for the  
 3 oncologists certainly in the Cancer Clinic  
 4 program?  
 5 MS. PREDHAM:  
 6 A. No, I'm very surprised actually and after all  
 7 the charts that I've reviewed, I'm still very  
 8 surprised. It didn't strike me when I went  
 9 through that there was a lot of patients in  
 10 that area of no recommendations that had to  
 11 wait--that, you know, I do--I can even  
 12 visualize, and of course, I'm tired and I'm  
 13 going through my memory here, but I've seen  
 14 evidence of Dr. McCarthy calling patients, you  
 15 know, to tell them the news on the phone.  
 16 MS. NEWBURY:  
 17 Q. Sure. But it certainly seemed to be an  
 18 approach of Dr. Siddiqui and one that was  
 19 consistent with direction given by Dr. Laing.  
 20 So unless the patient happened to be proactive  
 21 and know when to call and perhaps either call  
 22 the oncologist directly or perhaps call Nancy  
 23 Parsons and rely upon her to track down the  
 24 information, there might very well be patients  
 25 out there who are waiting for the call

Page 356

1 patiently and not taking the steps themselves  
 2 to make a call.  
 3 MS. PREDHAM:  
 4 A. Oh, certainly.  
 5 MS. NEWBURY:  
 6 Q. And might go for months without knowing the  
 7 results.  
 8 MS. PREDHAM:  
 9 A. Certainly, but I was never aware of that, that  
 10 that was a practice.  
 11 MS. NEWBURY:  
 12 Q. And given that it was the oncologists, in the  
 13 summer of 2005, who had expressed such concern  
 14 about anxiety for patients about knowing that  
 15 retesting is taking place but not yet having  
 16 the results, would it--I mean, does that  
 17 surprise you because it's now the oncologists  
 18 who had adopted this approach of simply  
 19 putting panel letters in the file for those  
 20 for whom no treatment change was recommended  
 21 and wait maybe three months or six months or  
 22 10 or 11 months?  
 23 MS. PREDHAM:  
 24 A. Oh yes. You know, obviously from the e-mails  
 25 that we saw today, I was aware of one lady who

Page 357

1 was going back for her annual appointment and  
 2 then was informed of the results, but I was  
 3 thinking that was more the unusual event,  
 4 rather than the routine.  
 5 MS. NEWBURY:  
 6 Q. Ms. Predham, are you able to indicate now what  
 7 the current number of retro converters are,  
 8 retro converters as you understand that  
 9 description?  
 10 MS. PREDHAM:  
 11 A. From a clinical point of view?  
 12 MS. NEWBURY:  
 13 Q. From whatever point of view you understand, I  
 14 guess. Whatever you understand a retro  
 15 conversion to include.  
 16 MS. PREDHAM:  
 17 A. The ones that were taken off Tamoxifen, I  
 18 would say would be four. But from a retro  
 19 converter from a true lab perspective on what  
 20 really is a false positive, in other words, I  
 21 don't have any idea what the number is.  
 22 MS. NEWBURY:  
 23 Q. Okay, and do you know if anyone in Eastern  
 24 Health has any idea what that total number is?  
 25 MS. PREDHAM:

Page 358

1 A. I know the analysis is underway and I just  
 2 have a general sense that they are looking at  
 3 that and answering those questions now. I  
 4 don't know where they are in progression of  
 5 that. I'm not involved.  
 6 MS. NEWBURY:  
 7 Q. And can you name the individuals that are  
 8 involved in that analysis?  
 9 MS. PREDHAM:  
 10 A. That would be Mr. Wayne Miller and Ms.  
 11 Pilgrim, and I guess, as well Dr. Denic and  
 12 Mr. Gulliver.  
 13 MS. NEWBURY:  
 14 Q. Okay. Now three of those witnesses, Dr. Denic  
 15 and Ms. Pilgrim and Mr. Gulliver, have all  
 16 given evidence since September, early  
 17 September I believe Dr. Denic gave his  
 18 evidence, and they weren't able to provide any  
 19 data at that time. So does that mean that the  
 20 analysis has only taken place since their  
 21 evidence?  
 22 MS. PREDHAM:  
 23 A. I'm not really sure. I do know that it's  
 24 underway. Of course, when the Centre for  
 25 Health Information came in and were updating

Page 359

1 the database and everything, it was we'd wait  
 2 until then, and I do know that Mr. Miller was  
 3 meeting with different people trying to get  
 4 the questions that they had, specific  
 5 questions to get the data for them. So that  
 6 was undergoing--that was underway definitely  
 7 the summer, and I do know--I thought that Dr.  
 8 Denic told me that he had some results back on  
 9 some of the questions that he had asked.  
 10 MS. NEWBURY:  
 11 Q. Okay. Ms. Predham, are you aware--certainly  
 12 my understanding that ER positive results were  
 13 not included in the NLCHI database. Do you  
 14 have any understanding what might have been  
 15 included there?  
 16 MS. PREDHAM:  
 17 A. They had an overall database. Their request  
 18 from the Department of Health was to create a  
 19 database of all patients who were retested at  
 20 Mount Sinai. So--and this is my understanding  
 21 and I'm sure they're going to be on later the  
 22 week anyway.  
 23 MS. NEWBURY:  
 24 Q. Yes.  
 25 MS. PREDHAM:

Page 360

1 A. But the analysis part that was conducted were  
 2 only on those that met the criteria of ER 30,  
 3 ER 10 and retested. So there are patients in  
 4 there who are positive that didn't meet the  
 5 criteria, that are in the database but they  
 6 weren't analyzed in a--they were excluded from  
 7 the analysis.  
 8 MS. NEWBURY:  
 9 Q. Okay. So do you know if the NLCHI database  
 10 would include a patient that was ER 30, PR 40  
 11 and converted to zero/zero?  
 12 MS. PREDHAM:  
 13 A. It could, I don't know, it could.  
 14 MS. NEWBURY:  
 15 Q. And you were shown a couple of lists that you  
 16 understood to be a picture in time of retro  
 17 converters and perhaps I could bring up the  
 18 longer list first, P-2642, please. And this  
 19 is one dated May 17, 2006 and you provided it  
 20 to Dr. Denic and that was based on information  
 21 from Dr. Cook. And did you understand this to  
 22 have been a comprehensive list of retro  
 23 converters to that date?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 361

1 MS. NEWBURY:  
 2 Q. Okay. And this still includes patients for  
 3 whom there ultimately was no change of  
 4 treatment because they might have initially  
 5 been considered negative.  
 6 MS. PREDHAM:  
 7 A. Right.  
 8 MS. NEWBURY:  
 9 Q. Okay.  
 10 MS. PREDHAM:  
 11 A. Correct.  
 12 MS. NEWBURY:  
 13 Q. And for the purposes of the shorter list, if a  
 14 patient had been considered and treated as  
 15 negative from the outset, that they would be  
 16 taken off the list.  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. They would no longer be considered a retro  
 21 converter for that purpose.  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 MS. NEWBURY:  
 25 Q. And do you know whether or not this list would

Page 362

1 reflect all of the results for retro  
 2 conversions for patients who are deceased or  
 3 known to be deceased at that time?  
 4 MS. PREDHAM:  
 5 A. I don't know. I know that there's one patient  
 6 there who is deceased, but I don't know if  
 7 that's including all of them. From the re-  
 8 tests I have no idea.  
 9 MS. NEWBURY:  
 10 Q. Now, a couple of months later--if I could  
 11 bring up P-0103 please. Ms. Pilgrim sends an  
 12 e-mail you and Sharon Smith identifying four  
 13 cases of retro converters who are living and  
 14 one deceased patient's husband has been  
 15 calling. This is--I'll show you now the  
 16 second page. Are you familiar with that e-  
 17 mail?  
 18 MS. PREDHAM:  
 19 A. I'd have to look at it again.  
 20 MS. NEWBURY:  
 21 Q. You can scroll down through it, the e-mail  
 22 that I'm referring to is the one on page two.  
 23 MS. PREDHAM:  
 24 A. I can scroll down?  
 25 MS. NEWBURY:

Page 363

1 Q. Yes. So, there's the longer e-mail that I'm  
 2 referring to.  
 3 MS. PREDHAM:  
 4 A. Okay.  
 5 MS. NEWBURY:  
 6 Q. So, that identifies the retro converters.  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. Now, this is subsequent to those two earlier  
 11 lists that you provided to Dr. Denic.  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 MS. NEWBURY:  
 15 Q. So, by that time it seems that the list is  
 16 wheedled down and is that based on excluding  
 17 patients for whom there was no change of  
 18 treatment?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MS. NEWBURY:  
 22 Q. And would it also exclude patients who were  
 23 known to be deceased?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 364

1 MS. NEWBURY:  
 2 Q. Okay. And is it your view that to do a true  
 3 analysis of retro converters, you would have  
 4 to include patients who are deceased?  
 5 MS. PREDHAM:  
 6 A. Oh yes.  
 7 MS. NEWBURY:  
 8 Q. And patients who did not require change of  
 9 treatment.  
 10 MS. PREDHAM:  
 11 A. Oh, you'd have to take the treatment side out  
 12 of it to get a full -  
 13 MS. NEWBURY:  
 14 Q. Yes, and it's your understanding as well that  
 15 an ER negative/PR positive patient who  
 16 converts to ER and PR negative would also be  
 17 considered a retro conversion.  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 MS. NEWBURY:  
 21 Q. If I could bring up Exhibit C-0276, please?  
 22 Ms. Predham, you can scroll through this.  
 23 It's a series of 9 letters, panel letters,  
 24 that I've located from documents that were  
 25 provided from you, from your files and these

Page 365

1 are the only nine that I was able to find,  
 2 again, subject to my own ability to identify  
 3 that. That would constitute or possibly  
 4 constitute retro conversions. Would you have  
 5 any reason to believe that there are more than  
 6 9 such panel letters?  
 7 MS. PREDHAM:  
 8 A. Oh, I wouldn't be able to tell you.  
 9 MS. NEWBURY:  
 10 Q. Oh, okay, just off top of your--I'm just  
 11 wondering, does the number -  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 MS. NEWBURY:  
 15 Q. - strike you as being low or -  
 16 MS. PREDHAM:  
 17 A. No.  
 18 MS. NEWBURY:  
 19 Q. And Ms. Predham, there's one panel letter that  
 20 is not reflected in either of your lists at P-  
 21 1373 or P-2642 and that's at page 3 of this  
 22 exhibit. And the patient there was diagnosed  
 23 with breast cancer in 2004. She was initially  
 24 40 estrogen or ER, zero for PR and a repeat  
 25 report from Mount Sinai, she was five and

Page 366

1 zero. And also second specimen from a  
 2 mastectomy was reported and it went from 10  
 3 ER, zero PR to zero and zero upon retesting.  
 4 And the recommendation of the panel which met  
 5 on February 16, 2006 that this patient is  
 6 considered to be hormone negative and  
 7 recommend that the patient's name not be given  
 8 further hormonal treatment for her metastatic  
 9 breast cancer.  
 10 Now, first of all, would that, based on  
 11 the information that you see there which I  
 12 guess is fairly limited, would that be a retro  
 13 conversion in your view?  
 14 MS. PREDHAM:  
 15 A. I don't know. It depends on the--I don't  
 16 know, I wouldn't be able to comment on it to  
 17 tell you the truth until I saw the name and  
 18 really, you know, the decisions about the--I  
 19 facilitated decisions about the retro  
 20 converters, but it was clinicians that made  
 21 the ultimately decision. So, I don't know.  
 22 MS. NEWBURY:  
 23 Q. Mr. Coffey, has the patient's name; that might  
 24 be of some assistance. Obviously without  
 25 divulging -

Page 367

1 MS. PREDHAM:  
 2 A. Yes, okay, yes.  
 3 MS. NEWBURY:  
 4 Q. I'm not sure if that's of any assistance to  
 5 you, Ms. Predham.  
 6 MS. PREDHAM:  
 7 A. There was something--there's some other thing  
 8 that was an issue there and it was something  
 9 to do with the second specimen. And I  
 10 remember, based on her name, that there was  
 11 something unusual with this situation.  
 12 MS. NEWBURY:  
 13 Q. Okay. And are you able to tell from this  
 14 letter and from being prompted by Mr. Coffey  
 15 with the patients name, whether or not this  
 16 patient had actually received any hormonal  
 17 therapy? I think the third paragraph there is  
 18 a little ambiguous as to whether or not she -  
 19 MS. PREDHAM:  
 20 A. I can't remember, but I remember there was  
 21 something, the whole situation was not a--oh,  
 22 thank you. I think it's an indication from  
 23 there, maybe the unusual thing was, was that  
 24 she was treated with Tamoxifen, but for a  
 25 short period of time and was taken off it

Page 368

1 before she was panelled.  
 2 MS. NEWBURY:  
 3 Q. Okay.  
 4 MS. PREDHAM:  
 5 A. And that may be the unusual thing about it.  
 6 MS. NEWBURY:  
 7 Q. Okay. But certainly the fact that she may  
 8 have been treated initially with Tamoxifen,  
 9 would that, in your understanding of things,  
 10 put her in the category of a retro conversion?  
 11 MS. PREDHAM:  
 12 A. Oh, certainly, in our criteria, she could have  
 13 been included in that.  
 14 MS. NEWBURY:  
 15 Q. Okay. And, of course, that's retro conversion  
 16 as being used here -  
 17 MS. PREDHAM:  
 18 A. From a treatment -  
 19 MS. NEWBURY:  
 20 Q. When you look at a category of four -  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 MS. NEWBURY:  
 24 Q. - which is what I think is still being used up  
 25 until Ms. Pilgrim's evidence -

Page 369

1 MS. PREDHAM:  
 2 A. Yes.  
 3 MS. PREDHAM:  
 4 A. - that's because that they've taken out the  
 5 deceased and they've taken out patients for  
 6 whom there was no change or treatment because  
 7 they were initially negative -  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MS. NEWBURY:  
 11 Q. - Treated was negative.  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 MS. NEWBURY:  
 15 Q. But this would not be in that category.  
 16 MS. PREDHAM:  
 17 A. There was, you know, again, it may have been--  
 18 she wasn't included in that category, no.  
 19 MS. NEWBURY:  
 20 Q. And do you think she should have been in the  
 21 category four?  
 22 MS. PREDHAM:  
 23 A. From here and from what I remember, she could  
 24 have been.  
 25 MS. NEWBURY:

Page 370

1 Q. Okay.  
 2 MS. PREDHAM:  
 3 A. But there is a memory that was something  
 4 complicated about this case and I can't  
 5 remember what that is.  
 6 MS. NEWBURY:  
 7 Q. Ms. Predham, there are a number of what would  
 8 appear to be retro conversions based certainly  
 9 on the clinical side of things, keeping in  
 10 mind that many people who have testified so  
 11 far have referred to a 10 percent cutoff, that  
 12 are apparent when looking at some data that  
 13 was provided to Mark Quinn at Exhibit P-0720--  
 14 if we could bring that up please--that are not  
 15 reflected on either of the two lists of retro  
 16 converters that were provided to Dr. Denic -  
 17 MS. PREDHAM:  
 18 A. Oh, okay.  
 19 MS. NEWBURY:  
 20 Q. - in May of 2006. I just wanted to show those  
 21 to you so that you're familiar with it before  
 22 I ask you questions. And these are the, I  
 23 think, the category of PR retro conversions  
 24 because the ERs were initially negative or  
 25 less than, say, 10, but the PRs were

Page 371

1 considered to be positive and upon retesting  
 2 at Sinai, several of the examples went 0, 0,  
 3 one went to 2, 0. And perhaps I'll show you  
 4 just to familiarize yourself with that. Line  
 5 20 of the data, negative 75, 2, 0. And you  
 6 have some doubts, I think from your earlier  
 7 evidence, as to whether that would be from a  
 8 technical point of view, a retro conversion.  
 9 MS. PREDHAM:  
 10 A. Well, no, I mean, the thing from a technical  
 11 point of view that I would have considered  
 12 that the lab would be very interested in is  
 13 that something would have 75 percent PR and  
 14 then go down to 0. The case with this person,  
 15 of course, is that that's two specimens for  
 16 the same person and that may be why it wasn't  
 17 picked up, because she was panelled or  
 18 panelled, I presumed, based on the other  
 19 results.  
 20 MS. NEWBURY:  
 21 Q. But the fact that, from a technical  
 22 perspective, and perhaps the labs interest in  
 23 this, the fact that that could have happened  
 24 on a specimen, whether or not there were other  
 25 specimens for that patient, that might have

Page 372

1 had consistent results upon retesting, the  
 2 fact that that could happen, do you think that  
 3 that would be of interest to the lab?  
 4 MS. PREDHAM:  
 5 A. Oh, definitely. The--you know, the other, it  
 6 would require investigation, of course, any of  
 7 this would require investigation just from my  
 8 limited knowledge of listening to them.  
 9 MS. NEWBURY:  
 10 Q. Uh-hm.  
 11 MS. PREDHAM:  
 12 A. Because I know, as I mentioned earlier, that  
 13 there was some discussion at the panel table  
 14 early on about needle core biopsies and how it  
 15 could change something, you know, from  
 16 pathology and could affect the results.  
 17 MS. NEWBURY:  
 18 Q. Okay.  
 19 MS. PREDHAM:  
 20 A. So, you know, the source specimen and all this  
 21 would have to be considered in part of that  
 22 analysis.  
 23 MS. NEWBURY:  
 24 Q. And you have no idea whether that situation I  
 25 just showed you, line 20, was needle core

Page 373

1 biopsy or not?  
 2 MS. PREDHAM:  
 3 A. Absolutely not, no, I don't.  
 4 MS. NEWBURY:  
 5 Q. That's something that would require  
 6 investigation?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 MS. NEWBURY:  
 10 Q. And line 61, there are apparently three  
 11 samples for a particular patient. One of  
 12 those three, it had 0 ER, 50/60 PR, and upon  
 13 retesting, it came out to be zero/zero, and  
 14 you note that the other two for that  
 15 particular patient, number 61, they were all  
 16 negatives?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 MS. NEWBURY:  
 20 Q. So in that case there, it might have actually  
 21 had an implication for the particular patient?  
 22 MS. PREDHAM:  
 23 A. Oh, definitely, and as part of the lab, would  
 24 be very concerned about this, but they'd also  
 25 have to start and get the original slides

Page 374

1 reread because, of course, the first person  
 2 that we thought was a retro convertor was  
 3 actually a misread slide.  
 4 MS. NEWBURY:  
 5 Q. Right.  
 6 MS. PREDHAM:  
 7 A. So they'd have to verify that and move on. so  
 8 it requires detailed analysis, but the lab  
 9 would be looking at something different than  
 10 the clinicians would be looking at.  
 11 MS. NEWBURY:  
 12 Q. They might have slightly broader concerns than  
 13 a clinician?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. And on that point that you just raised about  
 18 the fact that the first one that you looked at  
 19 was actually a misinterpretation of a slide,  
 20 and it probably should have been read as  
 21 negative all along -  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 MS. NEWBURY:  
 25 Q. Would that warrant a description other than

Page 375

1 retro conversion for that particular specimen?  
 2 MS. PREDHAM:  
 3 A. She wasn't considered a retro convertor.  
 4 MS. NEWBURY:  
 5 Q. She wasn't.  
 6 MS. PREDHAM:  
 7 A. No.  
 8 MS. NEWBURY:  
 9 Q. And from a patient's perspective, do you think  
 10 it would matter to the patient whether or not  
 11 the change result from positive to a negative  
 12 was due to misinterpretation of background  
 13 staining versus false nuclear staining? Do  
 14 you think that would matter to the patient?  
 15 MS. PREDHAM:  
 16 A. No.  
 17 MS. NEWBURY:  
 18 Q. And would it matter, I guess, to the lab in  
 19 terms of the numbers of such categories that  
 20 it responds to? I mean, is it any less of a  
 21 problem for the lab if they have all, say, 25  
 22 or whatever number there might be, that were  
 23 due to background staining, is that less of a  
 24 problem for the lab?  
 25 MS. PREDHAM:

Page 376

1 A. A different problem.  
 2 MS. NEWBURY:  
 3 Q. Different, okay, and perhaps it might  
 4 influence how the lab would approach the  
 5 investigation or the response to the problem?  
 6 MS. PREDHAM:  
 7 A. Exactly.  
 8 MS. NEWBURY:  
 9 Q. And just for communication purposes, given  
 10 that some of this information is being relayed  
 11 to the public or to the Department of Health,  
 12 for example, do you think it might warrant  
 13 further explanation rather than just saying  
 14 that this is not considered a retro  
 15 conversion.  
 16 MS. PREDHAM:  
 17 A. In hindsight, possibly.  
 18 MS. NEWBURY:  
 19 Q. Just a couple more to show you on the category  
 20 of PR retro conversions, for lack of a better  
 21 term. 142--the ones that I'm showing you, by  
 22 the way, are ones that I couldn't locate on  
 23 either of those lists of Dr. Denic in May of  
 24 2006. Here for line 142, we have less than 5  
 25 for ER, less than 25 for PR, going to

Page 377

1 zero/zero.  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 MS. NEWBURY:  
 5 Q. Now, of course, if that were 1998, it might  
 6 have been treated as clinically negative from  
 7 the outset.  
 8 MS. PREDHAM:  
 9 A. But again then from a lab perspective, it does  
 10 need to be investigated.  
 11 MS. NEWBURY:  
 12 Q. Right, because -  
 13 MS. PREDHAM:  
 14 A. And, of course, the person may be deceased  
 15 and, you know -  
 16 MS. NEWBURY:  
 17 Q. Right, so it may not have been panelled, but  
 18 it still would be a concern for the lab?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MS. NEWBURY:  
 22 Q. And line 436--I just want to show you because  
 23 there are quite a few that do not get picked  
 24 up on your lists or in the panel letters.  
 25 436, you have less than 10 for ER, 60 for PR,

Page 378

1 and then down to zero/zero for ER and PR upon  
 2 retesting. Line 717, again just one specimen  
 3 there, negative ER, greater than 60 for PR,  
 4 going to zero/zero upon retesting?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MS. NEWBURY:  
 8 Q. Line 767, there are several samples there for  
 9 the patient, two actually, and the second,  
 10 negative ER 40-50 PR, going to zero/zero upon  
 11 retesting, and it may not--I'm not even sure  
 12 what the X's mean there.  
 13 MS. PREDHAM:  
 14 A. I think, if I recall rightly, that that would  
 15 have been two blocks of the same specimen, as  
 16 opposed to two specimens.  
 17 MS. NEWBURY:  
 18 Q. Okay, and line 827, we have one specimen  
 19 there, negative ER, 60-70 PR, going to zero  
 20 and zero, and I won't take you through all of  
 21 them, but there were also conversions 10 ER,  
 22 10 PR going to zero/zero and I have located  
 23 those at lines 132, 239, 413 and 804. So  
 24 there's four in that category, according to  
 25 Mr.--the data given to Mr. Quinn, and on

Page 379

1 Exhibit P-2642, if I could bring that up,  
 2 please, it does acknowledge one that fits that  
 3 description.  
 4 MS. PREDHAM:  
 5 A. Okay, and the others may be those that are  
 6 deceased.  
 7 MS. NEWBURY:  
 8 Q. Right, okay. So here, it does acknowledge and  
 9 it indicates that that was panelled, 10/10,  
 10 zero/zero, and there's also another category,  
 11 you can see here down for the second Gander  
 12 one, the cursor is there, there's a category  
 13 of less than ten for ER and less than ten for  
 14 PR and zero and zero, and again that case was  
 15 panelled and confirmed to be negative, and  
 16 looking at Mark Quinn's data that was given to  
 17 him, there were actually a total of eight that  
 18 fit that category. So there were seven others  
 19 that fit this description that it doesn't  
 20 appear that they were panelled, and perhaps it  
 21 may not be as much of a concern from a  
 22 clinical perspective if it's below the ten  
 23 percent cut off, if indeed that's what was  
 24 used consistently by oncologists. But would  
 25 you agree that that would be of concern from a

Page 380

1 technical perspective for the lab?  
 2 MS. PREDHAM:  
 3 A. Oh definitely.  
 4 MS. NEWBURY:  
 5 Q. Okay, and if I can go back to Exhibit 0720,  
 6 please? And there are also a couple of, I  
 7 guess, stronger ER/PR conversions, 778. So  
 8 this is a 10 to 20 ER, a 40 to 50 PR and that  
 9 converts to zero/zero, and I couldn't find  
 10 that on either of the lists, and there's some  
 11 weaker ER conversions. Looking first at line  
 12 615.  
 13 MS. PREDHAM:  
 14 A. And this just highlights how important that  
 15 analysis be done on this, as opposed to  
 16 looking at the panel results.  
 17 MS. NEWBURY:  
 18 Q. Right, okay, and so there are two actually  
 19 with this example, lines 615 and 68, where the  
 20 results went from 20 ER to zero. You see line  
 21 615, there's one example, 20 to zero to  
 22 zero/zero upon retesting, and again, I  
 23 couldn't locate those on either of the two  
 24 lists that were given to Dr. Denic. And  
 25 despite all that, I think it's still the

Page 381

1 evidence that there were four retro  
 2 conversions and again it's your understanding  
 3 that this is because there was no treatment  
 4 change, and perhaps these were deceased  
 5 patients and not panelled.  
 6 MS. PREDHAM:  
 7 A. Um-hm.  
 8 MS. NEWBURY:  
 9 Q. And it was Dr. Denic's evidence that he'd  
 10 reviewed four of the retro conversions, but  
 11 there hadn't been a more extensive review, I  
 12 don't believe, of retro--of the conversions.  
 13 I think the focus was on those that had -  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MS. NEWBURY:  
 17 Q. - had a treatment change and were still living  
 18 patients. Now the final number of patients in  
 19 this list given to Mark Quinn, if we look down  
 20 right at the very bottom, and assuming this is  
 21 accurate, 887 patients. Now it's my  
 22 understanding that the NLCHI database, even  
 23 though it might have excluded some ER  
 24 positives, I'm not--I guess we'll have to wait  
 25 and get the evidence on that, but the NLCHI

Page 382

1 database is now over 1,000 patients that were  
 2 retested. Is that consistent with your  
 3 understanding?  
 4 MS. PREDHAM:  
 5 A. For the life of me, I can't remember how many  
 6 are in their database.  
 7 MS. NEWBURY:  
 8 Q. That's fine, but in any event, it seems that  
 9 there are -  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 MS. NEWBURY:  
 13 Q. - certainly more that have come to light since  
 14 then. So perhaps there are more retro  
 15 conversions as well, and I take it from your  
 16 evidence that you would agree that a further  
 17 analysis of this would be appropriate?  
 18 MS. PREDHAM:  
 19 A. Oh definitely. It has to be done.  
 20 MS. NEWBURY:  
 21 Q. And is there any reason why that wasn't done  
 22 before?  
 23 MS. PREDHAM:  
 24 A. Well, like I said, the timing of when it would  
 25 have been addressed would have been, you know,

Page 383

1 the winter or the spring of 2007. We also had  
 2 to make the decision about retesting all of  
 3 the deceased that hadn't been retested, and  
 4 you know, I wasn't able to do it, and then of  
 5 course, it got addressed again in May, June  
 6 and then the Centre for Health Information was  
 7 coming in. So it was decided to wait until  
 8 they did their exercise and then we'd use  
 9 their data.  
 10 MS. NEWBURY:  
 11 Q. Ms. Predham, I just wanted to ask you if you  
 12 could clarify something about panel letters  
 13 relating to some of the people on the longer  
 14 list at P-2642, please, and line two of this,  
 15 the patient was five ER, 25 PR and converted  
 16 to zero/zero and it indicates the patient was  
 17 panelled and there's no recommendation,  
 18 considered negative. I couldn't locate a  
 19 panel letter, and perhaps I don't have all of  
 20 them, but I couldn't locate one that related  
 21 to that particular patient and I'm wondering  
 22 how that patient might have been advised of  
 23 the recommendation or conclusions of the  
 24 panel.  
 25 MS. PREDHAM:

Page 384

1 A. It's not clear. I can't remember doing up  
 2 this list and whether it was myself and Kara,  
 3 when we went through that, you know, that I  
 4 wrote this in the side, oh that person, we  
 5 discussed that person at panel and there's--  
 6 you know, this person was confirmed negative.  
 7 There was no recommendation. If the person  
 8 was confirmed negative and no letter was  
 9 written, we would have notified that person  
 10 from Quality.  
 11 MS. NEWBURY:  
 12 Q. Okay, and so you would put that person's name  
 13 and information on a list and give it to Nancy  
 14 Parsons and she would make the call?  
 15 MS. PREDHAM:  
 16 A. Or I may have called. It would depend on the  
 17 circumstances.  
 18 MS. NEWBURY:  
 19 Q. Oh, okay, and would they be told that there  
 20 was actually a change of their results?  
 21 MS. PREDHAM:  
 22 A. Most likely we would have said that, you know,  
 23 these were your original results, and in 1998  
 24 when we reviewed your chart, you were  
 25 considered negative, and now your results are



Page 385

1 zero/zero, and you know, we may have given  
 2 that, in that level of detail, depending on  
 3 the circumstances of the phone call.  
 4 MS. NEWBURY:  
 5 Q. Okay, and would other members of the Quality  
 6 department have been in the same situation to  
 7 discuss, you know, and answer questions on  
 8 that particular point? It's a little  
 9 different than the patient that was  
 10 considered--you know, had zero/zero from the  
 11 beginning and confirmed to be zero/zero.  
 12 MS. PREDHAM:  
 13 A. Yes, but we did have--you know, over that  
 14 period of time, we did have ones that were not  
 15 probably so dramatic as that, but we did have  
 16 ones that were probably two and something and  
 17 came back as zero/zero.  
 18 MS. NEWBURY:  
 19 Q. Okay, and there are several other--if you look  
 20 down through that line six, seven and eight,  
 21 they all are noted to be scheduled for review,  
 22 but I couldn't locate any panel letters. Now  
 23 one of them is a little curious because it's  
 24 negative, negative going to zero, zero.  
 25 That's in line seven, I believe. No, six.

Page 386

1 MS. PREDHAM:  
 2 A. That may have been the same person there. See  
 3 where the bold lines are?  
 4 MS. NEWBURY:  
 5 Q. Um-hm.  
 6 MS. PREDHAM:  
 7 A. That may be the same, two specimens of the  
 8 same person.  
 9 MS. NEWBURY:  
 10 Q. Okay.  
 11 MS. PREDHAM:  
 12 A. I'm not sure.  
 13 MS. NEWBURY:  
 14 Q. And also lines 9, 11, 12, 14, 16, these were  
 15 all patients who were panelled but for whom  
 16 there were no letters that I could locate.  
 17 MS. PREDHAM:  
 18 A. Okay.  
 19 MS. NEWBURY:  
 20 Q. And you're comfortable though that these  
 21 patients would have all been contacted by now  
 22 certainly?  
 23 MS. PREDHAM:  
 24 A. Definitely by now. After the review that  
 25 we've done with the Centre for Health

Page 387

1 Information, they would find any gaps that we  
 2 would have in that.  
 3 MS. NEWBURY:  
 4 Q. Thank you very much, Ms. Predham. Those are  
 5 all the questions I have for you.  
 6 MS. PREDHAM:  
 7 A. Thank you.  
 8 THE COMMISSIONER:  
 9 Q. I understand the consensus of the room is that  
 10 we press on. Mr. Simmons, I'll look at you.  
 11 It's your witness.  
 12 MR. SIMMONS:  
 13 Q. All depends of course on how Ms. Predham is  
 14 feeling.  
 15 THE COMMISSIONER:  
 16 Q. It's one of those -  
 17 MR. SIMMONS:  
 18 Q. And (inaudible).  
 19 THE COMMISSIONER:  
 20 Q. - one of those things where it's a real  
 21 dilemma.  
 22 MS. PREDHAM:  
 23 A. A catch 22.  
 24 THE COMMISSIONER:  
 25 Q. How tired are you versus having to come back

Page 388

1 again another day.  
 2 MS. PREDHAM:  
 3 A. Not that I don't like seeing all your faces,  
 4 but I'd rather press on today.  
 5 THE COMMISSIONER:  
 6 Q. Yes, we'll take that one with a grain, Ms.  
 7 Predham. So we'll press on?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 THE COMMISSIONER:  
 11 Q. Mr. Crosbie?  
 12 CROSBIE, Q.C.:  
 13 Q. Thank you. I was going to avail of the high  
 14 level of technology that we've all become used  
 15 to here. I just want to raise the podium.  
 16 Perhaps I'll just lift it up. That's the  
 17 technology I meant there, this sturdy  
 18 cardboard box. Thank you. I'm estimating  
 19 about 40 minutes, by the way.  
 20 THE COMMISSIONER:  
 21 Q. All right.  
 22 MS. HEATHER PREDHAM--EXAMINATION BY CHESLEY CROSBIE, Q.C.  
 23 CROSBIE, Q.C.:  
 24 Q. I'd like to discuss with you, Ms. Predham,  
 25 first of all, the issue of quality and risk.

Page 389

1 Your job title speaks to responsibilities in  
 2 both areas, quality and risk, right?  
 3 MS. PREDHAM:  
 4 A. Yes.  
 5 CROSBIE, Q.C.:  
 6 Q. I guess, in my mind, and perhaps others,  
 7 quality would seem to be focused on processes  
 8 and systems that prevent adverse events. Does  
 9 that seem reasonable?  
 10 MS. PREDHAM:  
 11 A. Well, I define quality as broader than that.  
 12 It would be looking at processes and events  
 13 that could--could increase patient  
 14 satisfaction, could increase timeliness of  
 15 treatment, so not just limited to adverse  
 16 events.  
 17 CROSBIE, Q.C.:  
 18 Q. Not limited to safety, but satisfaction with  
 19 the--with the overall contact or experience of  
 20 the health care system?  
 21 MS. PREDHAM:  
 22 A. Satisfaction, utilization, efficiency, all  
 23 those issues. Quality would be the broad  
 24 umbrella of that. Safety would be one  
 25 component, but it would be a broad umbrella.

Page 390

1 CROSBIE, Q.C.:  
 2 Q. Risk would be focused on dealing with  
 3 situations that arise after an adverse event  
 4 has occurred, would that be fair?  
 5 MS. PREDHAM:  
 6 A. No, again I think that's the--that's the  
 7 reactive side of risk management, but the  
 8 proactive side of risk management is to  
 9 anticipate and determine what those issues can  
 10 be that would cause an adverse event, and stop  
 11 it before it happens.  
 12 CROSBIE, Q.C.:  
 13 Q. If--but you acknowledge that risk and risk  
 14 management has an after the event component,  
 15 which is important?  
 16 MS. PREDHAM:  
 17 A. Oh, definitely.  
 18 CROSBIE, Q.C.:  
 19 Q. And that includes managing situations where  
 20 legal recriminations are in the offing?  
 21 MS. PREDHAM:  
 22 A. Could be.  
 23 CROSBIE, Q.C.:  
 24 Q. In your job, you don't report to the insurer  
 25 on quality issues generally, do you?

Page 391

1 MS. PREDHAM:  
 2 A. No. I wouldn't say that I would report on  
 3 quality issues. It would have to be--it would  
 4 have to have some kind of implication that  
 5 would be reportable, that a potential claim  
 6 would arise.  
 7 CROSBIE, Q.C.:  
 8 Q. But you do report to them on risk issues?  
 9 MS. PREDHAM:  
 10 A. I would report to them on risk issues that  
 11 have happened, not on the proactive side of my  
 12 job. I would report on the reactive side.  
 13 CROSBIE, Q.C.:  
 14 Q. And risk issues that have happened would  
 15 include potential litigation, as well as  
 16 actual?  
 17 MS. PREDHAM:  
 18 A. Well, a potential claim is important to  
 19 identify, and part of--not the purpose of  
 20 occurrence reporting, but one of the benefits,  
 21 I guess, of occurrence reporting is that  
 22 you're aware of things before you actually get  
 23 litigation.  
 24 CROSBIE, Q.C.:  
 25 Q. No doubt. I believe you told the Commissioner

Page 392

1 that you have to follow instructions of the  
 2 insurer regarding liability questions or risk  
 3 losing coverage?  
 4 MS. PREDHAM:  
 5 A. I don't think I put it that way. I think we  
 6 would--if I did say that, on thinking about it  
 7 now, I wouldn't put it that way. I'd put that  
 8 we would have to consider it, and we'd also  
 9 take--you know, as the claim progressed, we  
 10 would have to, you know, follow requests of  
 11 the insurer and provide documents and policies  
 12 and that.  
 13 CROSBIE, Q.C.:  
 14 Q. Well, I gather loss of coverage is a  
 15 background issue?  
 16 MS. PREDHAM:  
 17 A. It would be a concern. I've never come across  
 18 an issue that we actually had loss of  
 19 coverage, but it would be a concern.  
 20 CROSBIE, Q.C.:  
 21 Q. You believe--you believed in this ER/PR  
 22 situation that you had to take the insurer's  
 23 instructions on disclosure to patients on what  
 24 to disclose and how to disclose it?  
 25 MS. PREDHAM:

Page 393

1 A. No, I don't think that was an issue. I don't  
 2 think we took what we had to disclose and how  
 3 to disclose it. We've disclosed in lots of  
 4 issues regarding various statements of claim,  
 5 and we've disclosed in that without  
 6 instruction from an insurer. We've told them  
 7 what we're going to say. If we're putting  
 8 something in writing, we might run the letter  
 9 by them, but we don't take direction on what  
 10 we're going to say.

11 CROSBIE, Q.C.:

12 Q. There are views, however, through Mr. Boone  
 13 were certainly sought?

14 MS. PREDHAM:

15 A. Oh, yes.

16 CROSBIE, Q.C.:

17 Q. Could we go to Document P-0287, page two,  
 18 please. While she's doing that, this is an  
 19 executive meeting, June 13th, 2007, which is  
 20 of course after certification was granted at  
 21 the end of May, 2007, and I realize that you  
 22 were not present there, but you do have  
 23 interactions with HIROC, the insurer. You see  
 24 Item 1.6, "CEO meeting with minister and  
 25 deputy minister".

Page 394

1 MS. PREDHAM:

2 A. Yes.

3 CROSBIE, Q.C.:

4 Q. And it goes on to say, "CEO is scheduled to  
 5 meet with the Deputy Minister of Health, Board  
 6 chairs, and CEO's, on June 14th, 2007, and  
 7 requested input on key messages", and amongst  
 8 those bullet items we can see education is the  
 9 first one, "To distinguish between errors  
 10 versus variation in medical treatment". The  
 11 second bullet is, "Move to a just culture",  
 12 and the fourth one is, "HIROC's concern with  
 13 full disclosure and the impact on  
 14 insurability". The item about full disclosure  
 15 seems to be linked to "just culture", and also  
 16 the errors.

17 MS. PREDHAM:

18 A. I would not be able to pass any comment on  
 19 that. I wasn't at that meeting. I certainly  
 20 don't know what the issue is there.

21 CROSBIE, Q.C.:

22 Q. May I suggest one reading is that this is a  
 23 statement that if Eastern Health made full  
 24 disclosure of errors, it could lose insurance  
 25 coverage?

Page 395

1 MS. PREDHAM:

2 A. Just to counter that, this was June of 2007,  
 3 and I don't know why that would be an issue at  
 4 that time.

5 CROSBIE, Q.C.:

6 Q. You can't help us out any further about what  
 7 that means?

8 MS. PREDHAM:

9 A. No. Mr. Tilley was a member of the board of  
 10 HIROC and maybe it was something that he  
 11 learned through that route. I don't know.

12 CROSBIE, Q.C.:

13 Q. Yes, he told us he was a member of the HIROC  
 14 board at a certain point in time.

15 MS. PREDHAM:

16 A. Yes.

17 CROSBIE, Q.C.:

18 Q. Now on the question of an ethics consult, in  
 19 2005, did it occur to you or was it discussed  
 20 in your presence that an ethics consult on  
 21 disclosure should be sought?

22 MS. PREDHAM:

23 A. Unfortunately not. It would have been quite  
 24 beneficial and it would have been a very good  
 25 exercise to go through and help us go through

Page 396

1 this.

2 CROSBIE, Q.C.:

3 Q. What if you did seek ethics advice, and the  
 4 advice was to make full disclosure in writing,  
 5 and HIROC was against that, what would happen?

6 MS. PREDHAM:

7 A. Well, I don't know, but that's a very, you  
 8 know, imaginary thing. HIROC wasn't against  
 9 disclosure in writing, the oncologists were  
 10 opposed to that at that time. I don't know  
 11 what would happen at that time. There would  
 12 be all feedback and a decision would have to  
 13 be made.

14 CROSBIE, Q.C.:

15 Q. We have seen input from Mr. Boone stating a  
 16 position that a letter should not go out for  
 17 fear of creating a cause of action. Do you  
 18 recall that?

19 MS. PREDHAM:

20 A. That was in October of '05?

21 CROSBIE, Q.C.:

22 Q. I believe it was, yes.

23 MS. PREDHAM:

24 A. I thought the feedback was communication at  
 25 that time, not necessarily a letter.

Page 397

1 CROSBIE, Q.C.:

2 Q. Is it possible, Ms. Predham, that the reason

3 nobody at Eastern Health--bring it back a

4 step. To those of us not embroiled in the day

5 to day management of this, I guess, crisis

6 situation, you'd agree that it could be

7 described as a crisis back in 2005 -

8 MS. PREDHAM:

9 A. Oh, I'd agree with that.

10 CROSBIE, Q.C.:

11 Q. To those of us not snarled up in the crisis,

12 it seems like an obvious avenue to follow to

13 seek an ethics consult about how to handle the

14 situation.

15 MS. PREDHAM:

16 A. Well, looking back, Mr. Crosbie, I have to

17 agree it would be an obvious thing to look

18 back it, and we didn't do it, and I can't

19 explain why we didn't do it.

20 CROSBIE, Q.C.:

21 Q. Could it be that the reason nobody at Eastern

22 Health asked for an ethics consult in 2005 is

23 that they did not want to be put in a

24 situation of conflicted loyalty and

25 potentially lose insurance coverage?

Page 398

1 MS. PREDHAM:

2 A. Absolutely not.

3 CROSBIE, Q.C.:

4 Q. That it was better not to get the ethics

5 advice?

6 MS. PREDHAM:

7 A. Absolutely not.

8 CROSBIE, Q.C.:

9 Q. The question--we've heard your description of

10 the meeting where a decision was made on

11 sending a letter or not sending a letter to

12 patients, and you described how Dr. Williams

13 banged his fist on the table and that sticks

14 in your memory?

15 MS. PREDHAM:

16 A. Yes.

17 CROSBIE, Q.C.:

18 Q. And said "call them".

19 MS. PREDHAM:

20 A. Yes.

21 CROSBIE, Q.C.:

22 Q. And your interpretation was that he was

23 getting frustrated with the delays in

24 formulating a letter and the logistics of

25 getting a letter out to patients?

Page 399

1 MS. PREDHAM:

2 A. Yes.

3 CROSBIE, Q.C.:

4 Q. Some of us remain mystified by why it is that

5 a letter could be such a logistical problem?

6 MS. PREDHAM:

7 A. I can only tell you what I remember, and I can

8 only tell you that I know that Dr. Williams

9 was frustrated with the discussion that was

10 ongoing at that time, and, you know, put an

11 end to it by saying "call them".

12 CROSBIE, Q.C.:

13 Q. Why not call them indeed, and send a letter

14 confirming what you've told them?

15 MS. PREDHAM:

16 A. We should have done that, and I do believe

17 that in my review in anticipation, I had

18 commented in some document that we were going

19 to do that, but that was something that was

20 overlooked and missed.

21 CROSBIE, Q.C.:

22 Q. Just lost in the swirl of events?

23 MS. PREDHAM:

24 A. Lost in the swirl.

25 CROSBIE, Q.C.:

Page 400

1 Q. I believe your evidence is that the disclosure

2 policy adopted in August, 2005, did not apply

3 to multiple or mass adverse events situations?

4 MS. PREDHAM:

5 A. I guess the message I was trying to get across

6 was that when we developed it, we weren't

7 thinking of this type of situation because we

8 hadn't come across anything this large beyond

9 a couple of patients, so we hadn't anticipated

10 this type of situation when we were writing

11 that disclosure policy. The focus of the

12 disclosure policy was individual patients.

13 CROSBIE, Q.C.:

14 Q. Indeed. Now you answered some questions from

15 my colleague about this issue, so I may have

16 missed some of the answer, but I may not be

17 the only person suffering from information

18 overload at this point. Just to press ahead

19 with that, did you review the disclosure

20 policies during the course of your involvement

21 in the ER/PR matter to see if you should be

22 conforming to them, or to determine whether or

23 not they were applicable?

24 MS. PREDHAM:

25 A. I--we didn't sit down and go through the

Page 401

1 guidelines at the time and say this is what we  
 2 were going to do, but, you know, as someone  
 3 who drafted it, Dr. Williams who commissioned  
 4 it, all the people, the players in there, were  
 5 intimately aware of those guidelines. I don't  
 6 think there was any need that we actually go  
 7 through that policy. We were aware of the  
 8 philosophy behind it.  
 9 CROSBIE, Q.C.:  
 10 Q. Are you aware of anyone who did review the  
 11 disclosure policies and who stated the result  
 12 of that review in your presence?  
 13 MS. PREDHAM:  
 14 A. No, I don't recall that.  
 15 CROSBIE, Q.C.:  
 16 Q. And stated whether or not the policy applied?  
 17 MS. PREDHAM:  
 18 A. I don't recall.  
 19 CROSBIE, Q.C.:  
 20 Q. And I guess there's nothing in writing to  
 21 evidence that anyone undertook that exercise,  
 22 is there?  
 23 MS. PREDHAM:  
 24 A. No.  
 25 CROSBIE, Q.C.:

Page 402

1 Q. Has anyone been tasked to write a disclosure  
 2 policy that applies to multiple or mass  
 3 patient situations?  
 4 MS. PREDHAM:  
 5 A. We're currently in the process, and someone in  
 6 our department is tasked with drafting out a  
 7 disclosure policy, a new disclosure policy,  
 8 and parts of that would be to identify  
 9 something of this nature, and, I guess, that's  
 10 the drafting--the group that's looking at it  
 11 is working through drafting on how to address  
 12 that.  
 13 CROSBIE, Q.C.:  
 14 Q. Excellent.  
 15 THE COMMISSIONER:  
 16 Q. The current one will go, and there will be a  
 17 new one which will encompass not only what you  
 18 would describe as one or two patient  
 19 incidents, but a larger thing, is that what  
 20 you said?  
 21 MS. PREDHAM:  
 22 A. Yes. The disclosure guidelines, the one from  
 23 the old Health Care Corp, was drafted with the  
 24 mindset of a certain type of incident. When  
 25 we became Eastern Health, the Canadian Patient

Page 403

1 Safety Institute guidelines on disclosure were  
 2 forthcoming, they were in the works. So we  
 3 put an interim one, which was fundamentally  
 4 the same policy, in place in anticipation that  
 5 shortly once those disclosure guidelines came  
 6 in, we would build on that and utilize that.  
 7 CROSBIE, Q.C.:  
 8 Q. Do you know if there's a draft in circulation  
 9 now?  
 10 MS. PREDHAM:  
 11 A. I'm not sure. I haven't been to work in the  
 12 past month or so, so I'm not sure. I know it  
 13 was tasked out and it was starting to look at--  
 14 the first thing that they would have to do  
 15 would be to research it, see if there's  
 16 anything else out there, that kind of thing.  
 17 So I'm not sure how far they've progressed.  
 18 CROSBIE, Q.C.:  
 19 Q. Could we have Document 56, please, P-0056,  
 20 page 18, and that's from the administrative  
 21 policy manual. It seems to have been signed  
 22 into effect August 1st, 2005.  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CROSBIE, Q.C.:

Page 404

1 Q. It is called "Guidelines on Disclosure of  
 2 Adverse Events", and between this and page 20,  
 3 I guess, is most of this--feel free to look  
 4 through with your mouse. Can you explain to  
 5 us what there is in this which does not apply  
 6 to multiple or mass adverse events situations?  
 7 MS. PREDHAM:  
 8 A. I guess there's--there may not be anything  
 9 that's specific to that, but I guess what I've  
 10 tried to portray is that the comfort level of--  
 11 or the perspective of going in this has been  
 12 that this is solely on a--something has  
 13 happened, you know the outcome, and you're  
 14 telling the patient.  
 15 CROSBIE, Q.C.:  
 16 Q. So that's your answer?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CROSBIE, Q.C.:  
 20 Q. To change topics, there are instances where  
 21 patients were not informed of changed test  
 22 results for many months, as we've seen?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CROSBIE, Q.C.:

Page 405

1 Q. You tried to follow up with physicians to  
 2 verify that they had met with patients, but  
 3 I'm getting the idea that you weren't happy  
 4 with the sort of response you got, or you  
 5 didn't get a satisfactory response back from  
 6 the physicians?  
 7 MS. PREDHAM:  
 8 A. Right.  
 9 CROSBIE, Q.C.:  
 10 Q. Just a questions in my mind, why not use a  
 11 form which required the responsible physician  
 12 to check off a box saying that he or she met  
 13 with the patient and then it had to be  
 14 returned to somebody responsible for tracking  
 15 compliance?  
 16 MS. PREDHAM:  
 17 A. That would be an excellent idea, but we didn't  
 18 do that, and even when we did the review this  
 19 time in 2008, we didn't do that either.  
 20 CROSBIE, Q.C.:  
 21 Q. Was there a reason for it or just wasn't  
 22 thought of?  
 23 MS. PREDHAM:  
 24 A. Never thought of it.  
 25 CROSBIE, Q.C.:

Page 406

1 Q. Because then if they don't return the form  
 2 within a given period of time that you give  
 3 them to do that, you can presume there's no  
 4 compliance and the patient has not been  
 5 informed, and then you can start to bug them?  
 6 MS. PREDHAM:  
 7 A. Oh, certainly.  
 8 CROSBIE, Q.C.:  
 9 Q. And you've got a central registry then of  
 10 what's happened?  
 11 MS. PREDHAM:  
 12 A. Exactly.  
 13 CROSBIE, Q.C.:  
 14 Q. Well, maybe next time.  
 15 MS. PREDHAM:  
 16 A. I will file that away.  
 17 CROSBIE, Q.C.:  
 18 Q. May we have Document P-0308, page one. Let's  
 19 see--I'm going to bring you down to the third  
 20 last paragraph, "Finally, I think we should be  
 21 aware that we will not be able to notify  
 22 everyone", and this was sent to Pilgrim,  
 23 Williams, Bonnell, and reading that, I guess a  
 24 person could draw the inference that at a high  
 25 level Eastern Health knew it would not be able

Page 407

1 to notify everyone from October, 2005?  
 2 MS. PREDHAM:  
 3 A. I guess you could say that. I had--I had  
 4 concerns just from our contacts. We had been  
 5 disclosing the confirmed negative results at  
 6 this time, so I had realized that we had  
 7 people that have moved and we had no other  
 8 contact information, so I was aware of those  
 9 problems then.  
 10 CROSBIE, Q.C.:  
 11 Q. A lady by the name of Rosalind Jardine  
 12 testified here on the third day of the  
 13 Commission hearings, and I get this  
 14 information from a review of the transcript  
 15 which I gather is publicly available,  
 16 Commissioner.  
 17 THE COMMISSIONER:  
 18 Q. Yes.  
 19 CROSBIE, Q.C.:  
 20 Q. Okay, so whatever I'm saying, if it comes from  
 21 the transcript, is public information.  
 22 THE COMMISSIONER:  
 23 Q. Yes.  
 24 CROSBIE, Q.C.:  
 25 Q. That's my understanding.

Page 408

1 THE COMMISSIONER:  
 2 Q. (Inaudible).  
 3 CROSBIE, Q.C.:  
 4 Q. Thank you.  
 5 THE COMMISSIONER:  
 6 Q. Any exhibits which would be C exhibits would  
 7 not be.  
 8 CROSBIE, Q.C.:  
 9 Q. I understand.  
 10 THE COMMISSIONER:  
 11 Q. This comes from the transcript. So Mrs.  
 12 Jardine was diagnosed in 1999 and had a  
 13 lumpectomy--diagnosed with breast cancer. She  
 14 had chemotherapy and she had radiation. Her  
 15 ER was read as zero here and PR 25 to 30, read  
 16 by Dr. Denic. Dr. Ganguly was equivocal on  
 17 whether she was a candidate for Tamoxifen, but  
 18 the medical oncologist--Ganguly, of course, is  
 19 radiation--was Dr. Laing and she decided that  
 20 the risks and rewards did not favour  
 21 Tamoxifen. So she decided or advised, I  
 22 guess, that Ms. Jardine was not a candidate  
 23 for that. Unfortunately, she had a recurrence  
 24 or a metastases was detected in September of  
 25 2005, and she received emergency surgery for

Page 409

1 that. She had her tissue sample read in  
 2 October, October 27th 2005 by Dr. Mullen at  
 3 Mount Sinai, and this returned a result of 50  
 4 percent ER and 20 percent PR. She was not  
 5 offered Tamoxifen in 2005 because it was  
 6 outside the time frame, which I guess is five  
 7 years that they were working with at that  
 8 time. She was offered other medications  
 9 instead, and I can inform the Commissioner  
 10 that I met with Ms. Jardine within the last  
 11 two weeks and she's doing well still.  
 12 Now what I'm leading around to is the  
 13 panel recommended no change in treatment for  
 14 Ms. Jardine because change in treatment had  
 15 already been implemented by Dr. Laing, who was  
 16 this lady's treating oncologist. In other  
 17 words, Dr. Laing didn't wait around for the  
 18 panel to make a recommendation. She acted as  
 19 soon as she knew the change in results.  
 20 MS. PREDHAM:  
 21 A. Yes.  
 22 CROSBIE, Q.C.:  
 23 Q. I guess we can have a look at C-0082, can we,  
 24 Commissioner?  
 25 THE COMMISSIONER:

Page 410

1 Q. Yes.  
 2 CROSBIE, Q.C.:  
 3 Q. Thank you, and we can bring this down a little  
 4 bit here. This letter is dated December 18,  
 5 2005, and you can see the second paragraph  
 6 says more or less what I had just reviewed,  
 7 that she had been treated by the time of this  
 8 letter, treated appropriately, therefore  
 9 there's no recommendation from the panel at  
 10 this time.  
 11 MS. PREDHAM:  
 12 A. Yes.  
 13 CROSBIE, Q.C.:  
 14 Q. Okay, and is this the--does this look like an  
 15 official panel letter to you? Is that the  
 16 form of a panel letter?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 CROSBIE, Q.C.:  
 20 Q. A recommendation letter?  
 21 MS. PREDHAM:  
 22 A. Yes.  
 23 CROSBIE, Q.C.:  
 24 Q. Okay.  
 25 MS. PREDHAM:

Page 411

1 A. The wording in the second paragraph would be--  
 2 well, would be different, depending on the  
 3 circumstances. But that's the format.  
 4 CROSBIE, Q.C.:  
 5 Q. Right. Okay, so what I'm getting around to  
 6 is, was she counted as one of the statistical  
 7 number of 117?  
 8 MS. PREDHAM:  
 9 A. Probably not. I think we had that discussion  
 10 with Ms. Chaytor and probably not.  
 11 CROSBIE, Q.C.:  
 12 Q. Okay, and so there would be others in a  
 13 similar situation?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CROSBIE, Q.C.:  
 17 Q. But you can't give us a number for how many?  
 18 MS. PREDHAM:  
 19 A. No. I mean, you know, we probably could  
 20 figure it out, but no, I can't.  
 21 CROSBIE, Q.C.:  
 22 Q. But not at the present moment you can't?  
 23 MS. PREDHAM:  
 24 A. No.  
 25 CROSBIE, Q.C.:

Page 412

1 Q. Okay. Could we have document P-3468, please?  
 2 This particular document seems to have  
 3 originated from John Rumboldt.  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CROSBIE, Q.C.:  
 7 Q. And who is that, please?  
 8 MS. PREDHAM:  
 9 A. He works at Department of Health. I'm not  
 10 sure what his position is.  
 11 CROSBIE, Q.C.:  
 12 Q. And there was no date on this. It appears to  
 13 be an e-mail from you, Heather. Is that  
 14 right?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 CROSBIE, Q.C.:  
 18 Q. To Mr. Rumboldt?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CROSBIE, Q.C.:  
 22 Q. Undated, but you believe that this was sent on  
 23 May 24, 2007?  
 24 MS. PREDHAM:  
 25 A. I think that because I was asked to locate the

Page 413

1 attachment, and I think it was in May 2007.  
 2 CROSBIE, Q.C.:  
 3 Q. In fact, I asked Ms. Chaytor if she could  
 4 inquire of Mr. Simmons what the date was, that  
 5 he could inquire of you. That goes back to  
 6 March 18th this year when I asked that, and I  
 7 got an answer on September 16th that the date  
 8 of the memo is May 24th, 2007.  
 9 MS. PREDHAM:  
 10 A. Okay.  
 11 CROSBIE, Q.C.:  
 12 Q. Is that what you think it is?  
 13 MS. PREDHAM:  
 14 A. When I was asked to find the attachment,  
 15 that's--that fits right with what I had to  
 16 look for.  
 17 CROSBIE, Q.C.:  
 18 Q. So that's -  
 19 MR. SIMMONS:  
 20 Q. That's in 3067 (inaudible).  
 21 CROSBIE, Q.C.:  
 22 Q. 3067. 3067 would be the inquiry.  
 23 MR. SIMMONS:  
 24 Q. No, it has the answer.  
 25 CROSBIE, Q.C.:

Page 414

1 Q. The answer. Oh, so you mean the question and  
 2 the answer -  
 3 MR. SIMMONS:  
 4 Q. The one that you have a copy of is embedded in  
 5 the lower part of this e-mail, 3067.  
 6 CROSBIE, Q.C.:  
 7 Q. Oh, I see. So they're both the same day. Is  
 8 that the idea?  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 CROSBIE, Q.C.:  
 12 Q. Ms. Predham, the inquiry and the answer was  
 13 the same day though?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 CROSBIE, Q.C.:  
 17 Q. Thank you. So the inquiry is "the Minister is  
 18 looking for the info by the four RHAs. Do we  
 19 have that?"  
 20 MS. PREDHAM:  
 21 A. I think that was a subsequent inquiry. I  
 22 think that was--when I sent him this one,  
 23 because it was 9:31 a.m., he came back at 9:40  
 24 asking me if there was info by four RHAs.  
 25 CROSBIE, Q.C.:

Page 415

1 Q. Okay. Well, let's go back to 3468? Thanks.  
 2 Okay, so May 24, 2007, happens to have been a  
 3 Friday and the last day of argument in the  
 4 certification hearing. Does that seem about  
 5 right?  
 6 MS. PREDHAM:  
 7 A. I can't remember that.  
 8 CROSBIE, Q.C.:  
 9 Q. Well, the Judge's decision, which was given  
 10 orally, was on the 27th of May.  
 11 MS. PREDHAM:  
 12 A. Okay.  
 13 CROSBIE, Q.C.:  
 14 Q. And so if you count back, that would mean--  
 15 well, that Friday, we were still arguing. So  
 16 it would be during the course of the hearing.  
 17 MS. PREDHAM:  
 18 A. Okay.  
 19 CROSBIE, Q.C.:  
 20 Q. Okay, so this was a hearing at which Eastern  
 21 Health placed reliance on the Dr. Gown  
 22 affidavit, and you're familiar with that  
 23 affidavit?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 416

1 CROSBIE, Q.C.:  
 2 Q. In fact, we could have a quick look at that.  
 3 P-0375, page two, please? And Eastern Health  
 4 placed reliance, amongst other things, on this  
 5 paragraph six which states "the seven year  
 6 average is 74 percent ER positivity," and you  
 7 see that?  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 CROSBIE, Q.C.:  
 11 Q. This may be a matter for when the NLCHI  
 12 witnesses come, but I just note in passing  
 13 that the reference is not to ER or PR  
 14 positivity, but just ER. But perhaps that's  
 15 for tomorrow. At the very moment, Eastern  
 16 Health was proffering the 74 percent to the  
 17 Court as a true positivity rate, you were  
 18 giving advice to someone in the Government who  
 19 was asking for information on behalf of the  
 20 Minister of Health. Is that right?  
 21 MS. PREDHAM:  
 22 A. I was locating a document, that I did not  
 23 prepare, and providing it to the Minister, to  
 24 the Department of Health.  
 25 CROSBIE, Q.C.:



Page 417

1 Q. Um-hm. So your answer is this short e-mail  
 2 with a table or two tables attached to it,  
 3 and, well, maybe you can just read the first  
 4 two paragraphs, not the last short sentence  
 5 but the first two, "here are the statistics"  
 6 and would you read that?  
 7 MS. PREDHAM:  
 8 A. "The weak positive category is the clinically  
 9 negative group. Up to 2000, it was 30 percent  
 10 and less. After 2000, it was ten percent--up  
 11 to 2000, it was 30 percent and less. After  
 12 2000, it was ten percent and less. In other  
 13 words, you have to add the negatives and the  
 14 weak positives together to get the number of  
 15 clinically negative."  
 16 CROSBIE, Q.C.:  
 17 Q. Thank you. And then if we can go to the  
 18 second page, which should be a table, I guess--  
 19 -oops, over shot. Is that your handwriting?  
 20 MS. PREDHAM:  
 21 A. No.  
 22 CROSBIE, Q.C.:  
 23 Q. Do you know whose?  
 24 MS. PREDHAM:  
 25 A. No.

Page 418

1 CROSBIE, Q.C.:  
 2 Q. Okay. This is the exhibit, page two. So  
 3 there we have a table, and if you can go to  
 4 page--sorry, go to strong positive percentage.  
 5 It's about four items down in the left-hand  
 6 column.  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 CROSBIE, Q.C.:  
 10 Q. You see strong positive and percentage.  
 11 THE COMMISSIONER:  
 12 Q. Are you able to see that there? Would you  
 13 like us to make it a little larger?  
 14 MS. PREDHAM:  
 15 A. No, I can see it.  
 16 CROSBIE, Q.C.:  
 17 Q. And then cross reference that with the column  
 18 "total DAKO" and you get 59 percent.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 CROSBIE, Q.C.:  
 22 Q. Do you see that there?  
 23 MS. PREDHAM:  
 24 A. Yes.  
 25 CROSBIE, Q.C.:

Page 419

1 Q. So what I'm submitting to you, Ms. Predham, is  
 2 that this document states the positivity rate  
 3 for 1997 through 2004 is actually 59 percent.  
 4 MS. PREDHAM:  
 5 A. This isn't my document. This is Mr.  
 6 Gulliver's document, but this only includes  
 7 the results from in the Health Care Corp.  
 8 That doesn't include the results from out of  
 9 town.  
 10 CROSBIE, Q.C.:  
 11 Q. And is that an important distinction?  
 12 MS. PREDHAM:  
 13 A. I just pointed out that it's incomplete data,  
 14 and I don't know what Dr. Gown based his--who  
 15 gave information to Dr. Gown and what he based  
 16 his affidavit on. But I'm only bringing that  
 17 forward is that I didn't prepare this document  
 18 and I only provided it to Mr. Rumboldt on his  
 19 request.  
 20 CROSBIE, Q.C.:  
 21 Q. Were you aware or did you recognize at the  
 22 time that there was an incongruity between the  
 23 74 percent that was being proffered to the  
 24 Court through the affidavit of Dr. Gown and  
 25 the 59 percent in this table?

Page 420

1 MS. PREDHAM:  
 2 A. I don't think I was aware because I don't  
 3 think I saw Dr. Gown's affidavit until after  
 4 it was filed in Court.  
 5 CROSBIE, Q.C.:  
 6 Q. When did you become aware of it?  
 7 MS. PREDHAM:  
 8 A. Aware of Dr. Gown's affidavit?  
 9 CROSBIE, Q.C.:  
 10 Q. Um-hm.  
 11 MS. PREDHAM:  
 12 A. I'm not sure. Somewhere along the way, but I  
 13 can't remember. I can't remember exactly.  
 14 CROSBIE, Q.C.:  
 15 Q. Was it soon after the certification  
 16 application?  
 17 MS. PREDHAM:  
 18 A. I really can't remember.  
 19 CROSBIE, Q.C.:  
 20 Q. When you did see it, did you become aware of  
 21 what I had just referred to as an incongruity?  
 22 MS. PREDHAM:  
 23 A. I certainly didn't pick it up. I only  
 24 discovered, in 2008, in fact that these  
 25 numbers here don't reflect ER positivity,

Page 421

1 which I always thought they did. They do  
 2 reflect hormonal positivity. So a combination  
 3 of ER and PR positivity.  
 4 THE COMMISSIONER:  
 5 Q. When you say these numbers here, are you  
 6 talking about that particular document you  
 7 have in front of you?  
 8 MS. PREDHAM:  
 9 A. Yes. So when it says--and I guess it's more  
 10 concerning when it's the ER negative and PR  
 11 positive, strong positive. They could be into  
 12 the strong positives, and this is Mr.  
 13 Gulliver's data and I wasn't aware of that  
 14 distinction when I had looked at it in  
 15 previous times. But I only became aware of  
 16 that in 2008.  
 17 CROSBIE, Q.C.:  
 18 Q. Okay. So your evidence now is this is based  
 19 on either or, if there was a positive ER or a  
 20 positive PR.  
 21 MS. PREDHAM:  
 22 A. It's a combination, and like I said, Mr.  
 23 Gulliver would have to speak to that. I  
 24 always thought it was only ER, but I found out  
 25 after it was a combination.

Page 422

1 CROSBIE, Q.C.:  
 2 Q. Because Dr. Gown states his 74 percent in  
 3 relation to ER.  
 4 MS. PREDHAM:  
 5 A. Yes.  
 6 CROSBIE, Q.C.:  
 7 Q. Do you know whether counting positive PRs  
 8 would increase the positivity rate or decrease  
 9 it?  
 10 MS. PREDHAM:  
 11 A. I have no idea.  
 12 CROSBIE, Q.C.:  
 13 Q. I think we'll see that it increases the  
 14 positivity rate when we hear from the  
 15 witnesses tomorrow. Last item, and I'm pretty  
 16 close on the mark of 40 minutes.  
 17 THE COMMISSIONER:  
 18 Q. You may get the prize, Mr. Crosbie.  
 19 CROSBIE, Q.C.:  
 20 Q. Do you have any familiarity with the idea that  
 21 a health care provider might owe a duty to a  
 22 patient to put the patient's interest ahead of  
 23 the interest of the health care provider?  
 24 MS. PREDHAM:  
 25 A. Well, yes. I mean, that's the priority of

Page 423

1 anybody in health care.  
 2 CROSBIE, Q.C.:  
 3 Q. That's not a foreign notion to you?  
 4 MS. PREDHAM:  
 5 A. No.  
 6 CROSBIE, Q.C.:  
 7 Q. In fact, that's a premise that you work with  
 8 in your job?  
 9 MS. PREDHAM:  
 10 A. Exactly.  
 11 CROSBIE, Q.C.:  
 12 Q. Let's say that there is such a duty. We'll  
 13 say hypothetically because I don't want to be  
 14 suggesting legal propositions, which are a  
 15 matter for argument. Let's say hypothetically  
 16 that there is such a duty to put the patients  
 17 interest first. In relation to disclosure, do  
 18 you see any conflict between your loyalty to  
 19 HIROC and your loyalty to patients?  
 20 MS. PREDHAM:  
 21 A. I don't see any conflict there, because HIROC  
 22 is the insurance provider we have now. If  
 23 Eastern Health went to tender tomorrow and  
 24 changed insurance providers, there wouldn't be  
 25 any loyalty there. We'd just have another

Page 424

1 insurance provider. And currently right now,  
 2 we have, depending on the time of claim and  
 3 occurrence and where it's located, we may deal  
 4 with up to three different insurance  
 5 providers.  
 6 CROSBIE, Q.C.:  
 7 Q. I'm not so much directly or posing the issue  
 8 in relation to HIROC, as I am to your capacity  
 9 in which it could be suggested you wear two  
 10 hats, the quality hat and the risk manager  
 11 hat. Do you see any inherent conflict between  
 12 your responsibilities for quality and your  
 13 responsibilities for risk?  
 14 MS. PREDHAM:  
 15 A. No, because a risk manager focus is on a safe  
 16 environment and safety to the patient. The  
 17 patient is always the focus and there's no--  
 18 nothing else would override that.  
 19 CROSBIE, Q.C.:  
 20 Q. Thank you very much.  
 21 MS. PREDHAM:  
 22 A. You're welcome.  
 23 THE COMMISSIONER:  
 24 Q. Thank you, Mr. Crosbie. Mr. Simmons?  
 25 MS. HEATHER PREDHAM, EXAMINATION BY MR. DANIEL SIMMONS

Page 425

1 MR. SIMMONS:  
 2 Q. Ms. Predham, I know you're happy to see me,  
 3 but you'll be even happier when you see me  
 4 leave again.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MR. SIMMONS:  
 8 Q. So I'll get right to the point as quickly as I  
 9 can with this. I'd like to go right back to a  
 10 couple documents that Mr. Crosbie just  
 11 referred you to and first of all, P-0375,  
 12 please. That's the affidavit from Dr. Gown  
 13 that you were referred to and we'll go to  
 14 paragraph six of that affidavit. The last  
 15 sentence says "I have been advised that the  
 16 seven-year average was 74 percent ER  
 17 positivity." Do you see any definition there  
 18 or description of what Dr. Gown is determining  
 19 to be a positive versus a negative result?  
 20 MS. PREDHAM:  
 21 A. No.  
 22 MR. SIMMONS:  
 23 Q. Okay. 3468, please, second page? This is the  
 24 other document Mr. Crosbie showed you and this  
 25 is the table that you forwarded on to Mr.

Page 426

1 Rumboldt which you say originated elsewhere,  
 2 and he referred you to the total number of  
 3 tests with strong positive percentage, which  
 4 is the fourth row. If you go farther down,  
 5 you'll see a row that says "tests reported  
 6 with positive staining, strong plus weak."  
 7 It's the second one from the bottom.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MR. SIMMONS:  
 11 Q. You see that?  
 12 MS. PREDHAM:  
 13 A. Yes.  
 14 MR. SIMMONS:  
 15 Q. And if you carry that over to total DAKO,  
 16 percentage there is 75.8 percent.  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 MR. SIMMONS:  
 20 Q. Does that seem consistent with Dr. Gown's  
 21 statement in his affidavit?  
 22 MS. PREDHAM:  
 23 A. Yes.  
 24 MR. SIMMONS:  
 25 Q. Okay. Now you've been asked a number of

Page 427

1 questions by a number of people about your  
 2 role as a risk manager, and you've made the  
 3 distinction between, I guess, what we'll call  
 4 claims management and risk management.  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 MR. SIMMONS:  
 8 Q. And if I understand correctly, you've said  
 9 that there is a proactive side to being a risk  
 10 manager and a reactive side. The management  
 11 of claims made by people where those claims  
 12 have to be reported to an insurer, is that the  
 13 reactive side of the role?  
 14 MS. PREDHAM:  
 15 A. Yes, it is.  
 16 MR. SIMMONS:  
 17 Q. Okay, and the proactive side involves doing  
 18 things which you do where there has been no  
 19 claim made against the organization and the  
 20 insurer is not involved -  
 21 MS. PREDHAM:  
 22 A. Exactly.  
 23 MR. SIMMONS:  
 24 Q. - in any capacity? Is that right?  
 25 MS. PREDHAM:

Page 428

1 A. Yes.  
 2 MR. SIMMONS:  
 3 Q. Okay. Can we have P-3369, please? Ms.  
 4 Predham, this is a document you provided me  
 5 with and you identified it earlier for Ms.  
 6 Chaytor as being related to the accreditation  
 7 program of the Canadian Council on Health  
 8 Services Accreditation, CCHSA.  
 9 MS. PREDHAM:  
 10 A. Yes.  
 11 MR. SIMMONS:  
 12 Q. And I believe you told us what time period  
 13 this came from, and I've forgotten.  
 14 MS. PREDHAM:  
 15 A. 2005.  
 16 MR. SIMMONS:  
 17 Q. 2005, so this is a fairly current statement  
 18 from CCHSA.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MR. SIMMONS:  
 22 Q. The very beginning there says that there is a  
 23 CCHSA aim standard which requires that the  
 24 governing body and managers prevent and manage  
 25 any risks to the organization. Do you know

Page 429

1 what an aim standard is? Do you know enough  
 2 about the accreditation process to give me  
 3 some idea about that?  
 4 MS. PREDHAM:  
 5 A. The CCHSA, the format they have, they have  
 6 standards and it's different, I guess,  
 7 different levels. The standard is an overall  
 8 standard and then they have different  
 9 criteria. I can't remember the terminology  
 10 right now. And part of the self-assessment  
 11 below the standard, they would have criteria  
 12 which you would have to rate yourself, rate  
 13 the organization against.  
 14 MR. SIMMONS:  
 15 Q. Uh-hm, okay. And do you understand this  
 16 section of the CCHSA standards to speak to  
 17 what's expected of an organization in its risk  
 18 management function?  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MR. SIMMONS:  
 22 Q. I'm just going to take you right on to page  
 23 six. There's some questions and answers here  
 24 and under this third question, it begins with  
 25 a statement, "Your overall objective is to

Page 430

1 minimize risk and poor outcomes and thereby  
 2 minimize liability." So it does speak to  
 3 minimizing liability, but as a result of  
 4 minimizing risk and poor outcomes, is that  
 5 consistent with your understanding of a risk  
 6 management role in the organization?  
 7 MS. PREDHAM:  
 8 A. Yes, the focus is always on the patient or  
 9 client or resident and as a side effect,  
 10 you're reducing liability.  
 11 MR. SIMMONS:  
 12 Q. Okay, and on the next page, there's a  
 13 question, "How does the concept of patient  
 14 client safety fit into risk management and  
 15 quality?" And I'm just going to read out the  
 16 answer there. It says, "CCHSA believes that  
 17 care cannot be of high quality unless it is  
 18 safe; therefore, patient safety has always  
 19 been a main concern for CCHSA. Your  
 20 organization's risk management and quality  
 21 management activities work together to improve  
 22 processes and outcomes and de-minimize risks.  
 23 From the point of view of accreditation, your  
 24 organization's self assessment on-site survey,  
 25 follow up on recommendations and use of

Page 431

1 indicators provide a great ability to detect,  
 2 prevent and learn from patient safety issues."  
 3 How does that fit with your understanding of  
 4 what the role of risk management is in your  
 5 organization?  
 6 MS. PREDHAM:  
 7 A. That fits my understanding.  
 8 MR. SIMMONS:  
 9 Q. Now I don't see anything in this document that  
 10 talks about the management of claims at all.  
 11 MS. PREDHAM:  
 12 A. No.  
 13 MR. SIMMONS:  
 14 Q. You've told us that there is a provincial  
 15 organization of sorts among risk managers in  
 16 health care in Newfoundland and Labrador?  
 17 MS. PREDHAM:  
 18 A. Yes.  
 19 MR. SIMMONS:  
 20 Q. Yes, can you just tell me a little bit of what  
 21 that's all about?  
 22 MS. PREDHAM:  
 23 A. Probably in 1998 the Nursing Homes Board  
 24 Association, the Health Care Board's  
 25 Association would have a meeting where quality

Page 432

1 people would get together once a year and talk  
 2 about different activities, from '96, '97.  
 3 And in '98, myself and the risk manager from  
 4 Western determined the need to have a group of  
 5 risk managers from across the province get  
 6 together to talk about issues that we were  
 7 facing and share information of similar  
 8 projects we were doing, policies that we were  
 9 doing. So at that time we established a risk  
 10 management network and we would meet by  
 11 conference call monthly and at a certain point  
 12 in time, we became a chapter in the American  
 13 Association of Health Care Risk Managers and  
 14 one of the key things that we've done as a  
 15 group is education for people, and educating  
 16 staff about root cause analysis, failure mode  
 17 and affects analysis.  
 18 MR. SIMMONS:  
 19 Q. Okay, and you've also provided me with a  
 20 document in relation to that, P-3055 please?  
 21 Now I understand this to be a promotional  
 22 brochure for a conference put off by that  
 23 organization in October of 2001?  
 24 MS. PREDHAM:  
 25 A. Yes, that was the first one we did and I guess

Page 433

1 one of the issues that we found was that the  
 2 education budgets of the health boards were  
 3 not very robust, so we weren't getting away to  
 4 any national conferences on risk management.  
 5 So we asked--well we decided how about if we  
 6 brought people here? So we organized this  
 7 organization and the two main people that we  
 8 had come speak to us was Catherine Tolton.  
 9 This was right after the cardiac surgery  
 10 inquest in Winnipeg, so she was the counsel  
 11 and came to tell us about the situation and  
 12 what they learned and it was a lot of system  
 13 errors and also about reporting of occurrences  
 14 and disclosure to the family were a lot of  
 15 issues that came out of that. And we also had  
 16 David U from the Institute for Safe Medication  
 17 Practice and really this was the first time we  
 18 heard about their work in the analysis,  
 19 subsequent analysis of medication occurrences  
 20 and what you can do with that on a trending  
 21 level and to increase reporting.  
 22 MR. SIMMONS:  
 23 Q. Okay. I'm not going to go through this  
 24 brochure in detail with you, but is it fair to  
 25 say that the topics that were discussed at

Page 434

1 this conference were generally related to  
 2 prevention of occurrences, identification of  
 3 risk and avoidance of harm, as opposed to  
 4 anything to do with the management of claims  
 5 once they're made against the organization?  
 6 MS. PREDHAM:  
 7 A. Oh definitely.  
 8 MR. SIMMONS:  
 9 Q. You've been asked many questions about HIROC,  
 10 the insurer. Am I correct in understanding  
 11 that HIROC, in addition to providing actual  
 12 insurance coverage as a commercial insurer  
 13 would, also provides some tools and assistance  
 14 from time to time on the prevention side as  
 15 well.  
 16 MS. PREDHAM:  
 17 A. Yes, they have a very strong risk management  
 18 side of their organization. One of the  
 19 biggest tools they have is RMSAM, we have two  
 20 things with very similar acronyms, it's Risk  
 21 Management Self Assessment Module. They base  
 22 it on actual claims across the country and  
 23 they look at--they analyze the claims and then  
 24 look at things that organizations can do a  
 25 self assessment of risk management strategies

Page 435

1 to prevent similar claims from happening in  
 2 their organization.  
 3 MR. SIMMONS:  
 4 Q. Right, so they would be aware from claims made  
 5 elsewhere of areas where there is potential  
 6 for patient harm?  
 7 MS. PREDHAM:  
 8 A. Yes.  
 9 MR. SIMMONS:  
 10 Q. And use that information to help other member  
 11 organizations to self assessments in those  
 12 particular areas?  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 MR. SIMMONS:  
 16 Q. Has Eastern Health or Health Care Corporation  
 17 before that participated in those self  
 18 assessments?  
 19 MS. PREDHAM:  
 20 A. Yes, we've done several, well the Health Care  
 21 Corporation did several, the other legacy  
 22 boards had done, the ones that were linked  
 23 with HIROC had done them and Eastern Health  
 24 has just completed one and I think we're in  
 25 the process now of getting ready for the next

Page 436

1 one.  
 2 MR. SIMMONS:  
 3 Q. Okay, and have you been involved in any of  
 4 those yourself?  
 5 MS. PREDHAM:  
 6 A. Peripherally. One of the members of our  
 7 department is the co-ordinator of that  
 8 project.  
 9 MR. SIMMONS:  
 10 Q. Right, okay, so although you've been in the  
 11 risk management role quite a bit, someone else  
 12 in quality has actually been the person  
 13 involved in this self assessment sponsored by  
 14 HIROC?  
 15 MS. PREDHAM:  
 16 A. Yes.  
 17 MR. SIMMONS:  
 18 Q. And I believe you could also give us an  
 19 example concerning information provided by  
 20 HIROC concerning sterilization equipment or  
 21 incident as another example?  
 22 MS. PREDHAM:  
 23 A. Back in, I think it might have been 2003 there  
 24 was a serious incident with sterilization of  
 25 critical or semi-critical equipment in Ontario

Page 437

1 and the government of Ontario mandated a full  
 2 review of all processes in all hospitals in  
 3 the sterilization of critical and semi-  
 4 critical equipment. We had, of course, read  
 5 about this and had planned to do the same  
 6 thing ourselves, but HIROC had the audit and  
 7 shared it with all the subscribers in case  
 8 they, you know, and actually encouraged them  
 9 to go through that process, so we used that  
 10 tool to go through that.

11 MR. SIMMONS:  
 12 Q. Okay. So that's another example, is it, of an  
 13 involvement in identifying potential hazards  
 14 and dealing with them before any harm  
 15 materialized from it.

16 MS. PREDHAM:  
 17 A. Yes.

18 MR. SIMMONS:  
 19 Q. Now, you've been shown P-0073 before, I'd like  
 20 to bring it up for just a minute, please.  
 21 This is from July 19th, 2005, it's your e-mail  
 22 message to Dr. Williams and others following a  
 23 conversation you had with HIROC. It concerns,  
 24 it's at the time at which disclosure is being  
 25 considered. In the third paragraph there,

Page 438

1 it's where you say "It's not that they don't  
 2 want us to disclose, they just don't want us  
 3 to disclose until we are sure of our facts."  
 4 Now, my first question is, did HIROC or anyone  
 5 on its behalf give any direction to you or  
 6 anyone at Eastern Health at this time  
 7 concerning the manner of disclosure and  
 8 whether there should be disclosure or anything  
 9 concerning the course of action that Eastern  
 10 Health was to take, any direction?

11 MS. PREDHAM:  
 12 A. No.

13 MR. SIMMONS:  
 14 Q. This appears, from the context of this e-mail  
 15 message to be that some advice was being given  
 16 of things to consider.

17 MS. PREDHAM:  
 18 A. Yes.

19 MR. SIMMONS:  
 20 Q. Is that a fair way to characterize it?

21 MS. PREDHAM:  
 22 A. Yes.

23 MR. SIMMONS:  
 24 Q. Between this time and the 10th of August which  
 25 was when the meeting was held where Dr. Laing,

Page 439

1 I think Dr. McCarthy were present and there is  
 2 discussion about whether the organization  
 3 should wait until results were back before  
 4 notifying patients. Between this message and  
 5 that meeting on the 10th of August, can you  
 6 tell me how much, if any, influence this  
 7 position communicated to you from HIROC had on  
 8 the organization delaying giving any  
 9 notification or making any public announcement  
 10 in that timeframe?

11 MS. PREDHAM:  
 12 A. The only influence would have been making sure  
 13 we had the story straight, but really because  
 14 the situation changed dramatically the next  
 15 day or we thought it changed probably two days  
 16 after that, little or no effect.

17 MR. SIMMONS:  
 18 Q. Okay. After the 10th of August, after the  
 19 oncologists make their position known on  
 20 disclosure, did this position continue to have  
 21 any influence at all on the course of action  
 22 the organization took after that time?

23 MS. PREDHAM:  
 24 A. No.

25 MR. SIMMONS:

Page 440

1 Q. I'm going to jump right up to September 30th  
 2 now. September 30th, you've told us that you  
 3 were in a meeting with Ms. Bonnell when the  
 4 call came The Independent concerning an  
 5 inquiry which led to The Independent story  
 6 being published on the 2nd of October. You've  
 7 told us you were meeting with Ms. Bonnell to  
 8 discuss a letter.

9 MS. PREDHAM:  
 10 A. Yes.

11 MR. SIMMONS:  
 12 Q. Form of a letter. You've told us that by that  
 13 time, the first results from Mount Sinai had  
 14 been returned a short time before.

15 MS. PREDHAM:  
 16 A. Yes.

17 MR. SIMMONS:  
 18 Q. Okay. Now, the letter that you were  
 19 discussing, who was that letter intended to be  
 20 directed to?

21 MS. PREDHAM:  
 22 A. The patients who were going to be retested.

23 MR. SIMMONS:  
 24 Q. So it would be going to the patients who would  
 25 be retested, as opposed to just those whose

Page 441

1 results had been returned?  
 2 MS. PREDHAM:  
 3 A. Yes.  
 4 MR. SIMMONS:  
 5 Q. Now that sounds like the type of letter that  
 6 was being discussed back in July, August of  
 7 2005.  
 8 MS. PREDHAM:  
 9 A. Yes.  
 10 MR. SIMMONS:  
 11 Q. So at that point were you picking up, in  
 12 essence, from where things had been left off?  
 13 MS. PREDHAM:  
 14 A. I guess we were re-evaluating the plan.  
 15 MR. SIMMONS:  
 16 Q. Okay, and was there any consideration being  
 17 given then by you or Ms. Bonnell to public  
 18 notice or announcement in addition to  
 19 preparing letters to go to the patients to  
 20 notify them that their samples were to be  
 21 retested?  
 22 MS. PREDHAM:  
 23 A. Well I guess that was part of the process. It  
 24 was, you know, we were looking at the plan  
 25 again, that was always part of the plan,

Page 442

1 notification of the patients and public  
 2 disclosure.  
 3 MR. SIMMONS:  
 4 Q. Okay, but I gather that that process, while it  
 5 had restarted, had not advanced very far  
 6 before The Independent story got ahead of it.  
 7 MS. PREDHAM:  
 8 A. Oh no, this was our first action.  
 9 MR. SIMMONS:  
 10 Q. Okay. Now I'll bring you right now to P-0092  
 11 please? This is the e-mail message from Mr.  
 12 Boone on the 18th of October, 2005, you've  
 13 told us that you did not see this message  
 14 until after your meeting that day with Dr.  
 15 Williams and others at which the decision was  
 16 made to phone patients instead of sending a  
 17 letter, is that correct?  
 18 MS. PREDHAM:  
 19 A. Yes.  
 20 MR. SIMMONS:  
 21 Q. You've told us that in your conversation with  
 22 Mr. Boone, you understood him to be hesitant  
 23 and my question is what, on the phone, did you  
 24 understand him to be hesitant about the  
 25 organization doing?

Page 443

1 MS. PREDHAM:  
 2 A. Hesitant about disclosing.  
 3 MR. SIMMONS:  
 4 Q. About disclosing. Was the hesitation confined  
 5 to the sending of a letter or was it more  
 6 generally about making contact with patients  
 7 at that time?  
 8 MS. PREDHAM:  
 9 A. Oh it was hesitancy about contacting patients,  
 10 not the letter.  
 11 MR. SIMMONS:  
 12 Q. When you communicated that hesitancy to Dr.  
 13 Williams, how did you communicate it? What  
 14 message did you give him?  
 15 MS. PREDHAM:  
 16 A. I told him that, you know, a brief  
 17 conversation, that Mr. Boone had expressed  
 18 hesitancy in communicating with patients and  
 19 Dr. Williams said it's too late for that now,  
 20 we're going ahead.  
 21 MR. SIMMONS:  
 22 Q. Okay, and at that meeting a decision was made  
 23 to communicate to the patients, not by letter,  
 24 but by telephone?  
 25 MS. PREDHAM:

Page 444

1 A. Yes.  
 2 MR. SIMMONS:  
 3 Q. So did the hesitancy that was communicated by  
 4 your to Dr. Williams, in your view did that  
 5 have any impact at all on the discussion on  
 6 the decision that was made at that meeting?  
 7 MS. PREDHAM:  
 8 A. Oh no, Dr. Williams disregarded it.  
 9 MR. SIMMONS:  
 10 Q. Now, throughout this whole piece in relation  
 11 to disclosure to patients, was there ever any  
 12 direction from the insurer that the  
 13 organization had to take any particular action  
 14 or was prohibited from taking any particular  
 15 action in relation to disclosure?  
 16 MS. PREDHAM:  
 17 A. No.  
 18 MR. SIMMONS:  
 19 Q. Were you ever told by anyone, the insurer or  
 20 on its behalf, that there was going to be any  
 21 consequences as a result of ignoring any  
 22 advice from the insurer in relation to  
 23 disclosure?  
 24 MS. PREDHAM:  
 25 A. No.

Page 445

1 MR. SIMMONS:  
 2 Q. And in fact, the organization did ignore  
 3 advice, correct?  
 4 MS. PREDHAM:  
 5 A. Yes, yes.  
 6 MR. SIMMONS:  
 7 Q. And were there any consequences as a result of  
 8 ignoring the advice?  
 9 MS. PREDHAM:  
 10 A. No, there wasn't.  
 11 MR. SIMMONS:  
 12 Q. You've been asked a number of questions about  
 13 external review reports prepared by Dr.  
 14 Banerjee and Ms. Wegrynowski and when Ms.  
 15 Chaytor was questioning you, she went through  
 16 one of the reports and had you identify areas  
 17 which you considered to be matters of fact and  
 18 areas which would be matters of opinion.  
 19 MS. PREDHAM:  
 20 A. Yes.  
 21 MR. SIMMONS:  
 22 Q. Because you had said that factual matters were  
 23 not caught under the confidentiality that  
 24 surrounded the reports, but opinions generally  
 25 were.

Page 446

1 MS. PREDHAM:  
 2 A. Yes.  
 3 MR. SIMMONS:  
 4 Q. Do you recall that?  
 5 MS. PREDHAM:  
 6 A. I do.  
 7 MR. SIMMONS:  
 8 Q. Okay. So first of all then, aside from any  
 9 legal protections provided by the Evidence Act  
 10 to those reports, is it correct to say that  
 11 there is an underlying concern for  
 12 confidentiality that's grounded in promoting  
 13 full disclosure by people involved in a peer  
 14 review and quality assurance process?  
 15 MS. PREDHAM:  
 16 A. Yes, that's fair.  
 17 THE COMMISSIONER:  
 18 Q. I'm sorry, would you say that again?  
 19 MR. SIMMONS:  
 20 Q. The principle behind wanting to promote  
 21 confidentiality in the peer review and quality  
 22 assurance process is to promote full  
 23 disclosure and open discussion by the  
 24 participants in the process?  
 25 MS. PREDHAM:

Page 447

1 A. Yes.  
 2 MR. SIMMONS:  
 3 Q. And that's generally accepted within health  
 4 care, is it?  
 5 MS. PREDHAM:  
 6 A. Yes.  
 7 THE COMMISSIONER:  
 8 Q. The principle behind confidentiality is  
 9 promotion of full disclosure by the  
 10 participants in the process. Who are the  
 11 participants?  
 12 MS. PREDHAM:  
 13 A. Well it depends on the actual peer review--the  
 14 quality review. Sometimes it could be the  
 15 nurses or the team physicians, you'd want them  
 16 to be able to feel comfortable speaking their  
 17 mind and that you're not going to go around  
 18 saying this is what so and so said.  
 19 MR. SIMMONS:  
 20 Q. So is one of the objectives then that you want  
 21 people who are interviewed or who give  
 22 information to the reviewers to be able to  
 23 speak in confidence to that?  
 24 MS. PREDHAM:  
 25 A. Yes.

Page 448

1 MR. SIMMONS:  
 2 Q. And is it that you want the people who are  
 3 speaking to the reviewers to feel free to give  
 4 their opinions?  
 5 MS. PREDHAM:  
 6 A. Oh definitely.  
 7 MR. SIMMONS:  
 8 Q. And do you want the reviewers to feel free to  
 9 give their opinions as well?  
 10 MS. PREDHAM:  
 11 A. Yes.  
 12 MR. SIMMONS:  
 13 Q. Okay. Now, when the review results in a  
 14 report that contains facts, you've said that  
 15 those facts are not confidential, those facts  
 16 can be disclosed, so that if, for example, a  
 17 review here were to say, there was no check  
 18 list for the tissue processor, that would be a  
 19 fact which the organization would be free to  
 20 disclose, right?  
 21 MS. PREDHAM:  
 22 A. Certainly.  
 23 MR. SIMMONS:  
 24 Q. Would you feel that you'd be free to disclose  
 25 that that was discovered as part of the



Page 449

1 quality review; in other words, that it came  
 2 out of the quality review process?  
 3 MS. PREDHAM:  
 4 A. No, I think we'd prefer to say that it was we  
 5 don't have this, we don't, you know, this is a  
 6 fact of the case that this does not exist. We  
 7 wouldn't say the reviewer has told us this did  
 8 not exist or this is the information we got  
 9 out of there.  
 10 MR. SIMMONS:  
 11 Q. Okay, so by taking that approach, would you be  
 12 protecting the confidences of the people who  
 13 participated in the peer review process?  
 14 MS. PREDHAM:  
 15 A. Yes.  
 16 MR. SIMMONS:  
 17 Q. Only a couple more items.  
 18 MS. PREDHAM:  
 19 A. Thank you.  
 20 MR. SIMMONS:  
 21 Q. You've mentioned a couple of times that in the  
 22 spring of '06, you consulted with the health  
 23 research unit about potential analysis of the  
 24 test results once they all became available.  
 25 MS. PREDHAM:

Page 450

1 A. Yes.  
 2 MR. SIMMONS:  
 3 Q. Now can you tell me a little more about why  
 4 you were consulting, who you spoke with, what  
 5 you found out, where that went?  
 6 MS. PREDHAM:  
 7 A. Well all along or throughout this process, Dr.  
 8 Cook and I had talked numerous times about  
 9 having to do an analysis of the data and I  
 10 guess going through the panelling process that  
 11 became, you know, more evident and when we  
 12 finished, when we got all the results back,  
 13 we're going to have to do a full analysis of  
 14 that.  
 15 MR. SIMMONS:  
 16 Q. Uh-hm.  
 17 MS. PREDHAM:  
 18 A. So I went over to the health research unit and  
 19 met with a biostatistician to give him a broad  
 20 description of the type of information that we  
 21 had and the circumstances in which this  
 22 evolved, very, very board. And when we were  
 23 going--because I wanted to make sure that we  
 24 had the information available and in the, you  
 25 know, in the format that he would need or

Page 451

1 whatever, and that they would agree to do it.  
 2 So when we had that discussion, that was the  
 3 type of things that we covered, the type of  
 4 information that he would need, anything that  
 5 would influence the results over the time  
 6 period, you know, this type of issue.  
 7 MR. SIMMONS:  
 8 Q. Okay. And what came of that consultation?  
 9 What were the results of that then?  
 10 MS. PREDHAM:  
 11 A. Well, he--well it became evident that I needed  
 12 more concrete information. There was going to  
 13 be a little bit of--there was going to have to  
 14 be some decisions made around parameters of  
 15 change, for instance, so if somebody's results  
 16 were, you know, originally zero and came back  
 17 30, did that mean the same as if they were,  
 18 you know, PR 60 and came back as PR 90, you  
 19 know, so what was--what were the significant  
 20 areas of change. Was it a number? Was it  
 21 numerically, you know, so five percent was  
 22 significant, ten percent was significant or  
 23 less than five was not, or did it matter on,  
 24 you know, whether it was in the high  
 25 positives, did that matter if that was a

Page 452

1 change. So that would be something that we  
 2 would either have to get from research or from  
 3 the pathology world.  
 4 MR. SIMMONS:  
 5 Q. So that was a beginning in considering what  
 6 could be done about analysis of the  
 7 information. Now from following on that then,  
 8 the--if I understand from what you've said,  
 9 before the process of completing and the  
 10 collection of the data, dealing with the  
 11 special cases and so on had to be completed,  
 12 was there a plan to go back to that kind of  
 13 approach that you discussed with the health  
 14 research unit once the retesting data was all  
 15 collated and prepared?  
 16 MS. PREDHAM:  
 17 A. Oh yes, it was always a plan to do that.  
 18 MR. SIMMONS:  
 19 Q. Okay, one final thing I just want to ask you  
 20 about, a minor point, in Exhibit P-2976  
 21 please? I'm doing my best to move along  
 22 quickly.  
 23 MS. PREDHAM:  
 24 A. That's good, I appreciate it.  
 25 MR. SIMMONS:

Page 453

1 Q. You were asked about this request from the  
 2 Muse, the Memorial University Student  
 3 Newspaper for answers to some questions and  
 4 this was the version that Ms. Pilgrim sent to  
 5 you which she described as the final version  
 6 and you were shown this in question three  
 7 where it said, "We anticipate that eight to  
 8 ten percent of those being retested will be  
 9 affected." And I just want to show you P-0665  
 10 please? This is a subsequent e-mail from  
 11 Dianne Smith whom you've identified as Ms.  
 12 Pilgrim's assistant, to a Mandy LeRiche, who I  
 13 believe was the Muse correspondent and it has  
 14 copies of the answers that actually went to  
 15 the Muse and in No. 3 it says, "We anticipate  
 16 that less than ten percent of patients will be  
 17 affected." Now, did that statement accord  
 18 more with what you had understood Dr. Williams  
 19 to be publicly stating up to that time?  
 20 MS. PREDHAM:  
 21 A. I think it does, you know, it's hard to  
 22 remember right now, but I think it does.  
 23 MR. SIMMONS:  
 24 Q. Yes, okay, good. Okay, thank you, Ms.  
 25 Predham, I don't have anything further for

Page 454

1 you.  
 2 MS. PREDHAM:  
 3 A. Thank you.  
 4 THE COMMISSIONER:  
 5 Q. Thank you. Anything arising Ms. Chaytor?  
 6 CHAYTOR, Q.C.:  
 7 Q. Commissioner, there is a potential question  
 8 arising; however, it concerns an exhibit  
 9 that's on hold right now and until we can work  
 10 that out with counsel for Eastern Health, I  
 11 don't know that I can ask the question.  
 12 THE COMMISSIONER:  
 13 Q. Okay. We have these little problems from time  
 14 to time, Ms. Predham.  
 15 MS. PREDHAM:  
 16 A. I can imagine.  
 17 THE COMMISSIONER:  
 18 Q. The basic message is that while I will be  
 19 telling you thank you very much for your  
 20 assistance in this matter, there is a  
 21 possibility that there may be another question  
 22 at some point in the next week or so and I'm  
 23 sure counsel will be talking with Mr. Simmons  
 24 and they will let you know as quickly as  
 25 possible what the resolution of that is

Page 455

1 because I have no idea what they're talking  
 2 about.  
 3 MS. PREDHAM:  
 4 A. Okay.  
 5 EXAMINATION BY THE COMMISSIONER  
 6 THE COMMISSIONER:  
 7 Q. There is one question though arising out of  
 8 matters raised by Mr. Simmons that I would  
 9 like you to clarify for me. And that is the  
 10 business of what you and Ms. Bonnell were  
 11 doing on that faithful day in September when  
 12 the call came from The Independent.  
 13 MS. PREDHAM:  
 14 A. Yes.  
 15 THE COMMISSIONER:  
 16 Q. And as you described it in answer or perhaps  
 17 more Mr. Simmons described it and you agreed  
 18 with his description, that this was sort of a  
 19 picking up--I'm not sure where I got this  
 20 idea, whether it was from your evidence or  
 21 perhaps from Ms. Bonnell who had been here  
 22 quite some time ago, but my impression was  
 23 that Ms. Bonnell in particular was most  
 24 anxious that one get on with this and that  
 25 actions be taken. So what I'm interested in

Page 456

1 knowing was, was this the large group deciding  
 2 it was time to do this or was this you and Ms.  
 3 Bonnell trying to push it to get something  
 4 started, to get something done, to get the  
 5 thing moving again? Or perhaps some third  
 6 alternative that I haven't thought of.  
 7 MS. PREDHAM:  
 8 A. Well it was, the whole thing, it was like  
 9 something hanging over your head all summer,  
 10 you know, no one--we agreed with it when Dr.  
 11 Laing brought up the issue and so eloquently  
 12 spoke to it, I could certainly see her point  
 13 and we went with it, but you just, you know,  
 14 it didn't sit right. It didn't, you were okay  
 15 with it, but, you know, it didn't settle and I  
 16 guess this was Ms. Bonnell's and my first  
 17 attempt of okay, let's get this started again,  
 18 let's get together, we'll do that and, you  
 19 know.  
 20 THE COMMISSIONER:  
 21 Q. So that was sort of two of the people whom one  
 22 might say were involved in the group trying to  
 23 make initial steps, what in your view might be  
 24 bringing it back on course, is that fair?  
 25 MS. PREDHAM:

1 A. Yes, yes.  
2 THE COMMISSIONER:  
3 Q. Okay, thank you. And that was the only one  
4 question you had, Ms. Chaytor?  
5 MS. CHAYTOR:  
6 Q. Yes, that's it.  
7 THE COMMISSIONER:  
8 Q. Well, it is for me, thank you very much. I  
9 know it has been a long few days on your part  
10 and I very much appreciate your coming.  
11 Frankly, I was interested in finally meeting  
12 you because so many people said "Ms. Predham  
13 will know that" and that's one of the reasons  
14 you have been here for such a long period of  
15 time. Thank you very much.  
16 MS. PREDHAM:  
17 A. Thank you.  
18 THE COMMISSIONER:  
19 Q. See the rest of you in the morning at 9:30.  
20 Upon conclusion at 6:15 p.m.

1 CERTIFICATE  
2 I, Judy Moss, hereby certify that the foregoing is  
3 a true and correct transcript in the matter of the  
4 Commission of Inquiry on Hormone Receptor Testing,  
5 heard on the 22nd 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 22nd day of October, A.D., 2008  
13 Judy Moss

Inquiry on Hormone Receptor Testing

<p style="text-align: center;"><b>-&amp;-</b></p> <p><b>&amp;</b> [1] 137:6</p> <hr/> <p style="text-align: center;"><b>-?-</b></p> <p><b>'03</b> [1] 231:22  <b>'05</b> [3] 11:9 99:20 396:20  <b>'06</b> [12] 37:12 69:10 70:9      112:1 117:13 122:10      155:21,23 157:13,15      192:23 449:22  <b>'07</b> [4] 11:10 185:17      188:4 249:22  <b>'96</b> [2] 331:2 432:2  <b>'97</b> [4] 90:21 155:10      296:21 432:2  <b>'97/'98</b> [1] 156:8  <b>'98</b> [1] 432:3</p> <hr/> <p style="text-align: center;">---</p> <p><b>-and</b> [1] 137:17  <b>-oops</b> [1] 417:19  <b>-or</b> [2] 6:1 404:11  <b>-the</b> [1] 403:14  <b>-there's</b> [1] 290:18  <b>-this</b> [1] 121:13</p> <hr/> <p style="text-align: center;"><b>-0-</b></p> <p><b>0</b> [12] 143:4,11,12,12,13      154:11 371:2,2,3,5,14      373:12  <b>0106</b> [1] 211:25  <b>0276</b> [1] 294:5  <b>0720</b> [1] 380:5  <b>0815</b> [2] 5:24 6:1</p> <hr/> <p style="text-align: center;"><b>-1-</b></p> <p><b>1,000</b> [1] 382:1  <b>1.6</b> [1] 393:24  <b>10</b> [14] 132:5 143:14      154:11 225:22 228:7      356:22 360:3 366:2      370:11,25 377:25 378:21      378:22 380:8  <b>10/10</b> [1] 379:9  <b>101</b> [3] 15:9 18:12 43:3  <b>10:30</b> [1] 293:20  <b>10th</b> [4] 225:18 438:24      439:5,18  <b>11</b> [4] 226:24 228:7      356:22 386:14  <b>117</b> [19] 159:5 160:10,17      160:21 161:16 162:8,11      164:8,10 165:11 170:21      171:4,18 176:16 177:5      177:10,18 212:22 411:7  <b>11th</b> [2] 8:4 29:4  <b>12</b> [5] 135:9 151:20,23      228:3 386:14  <b>1207</b> [1] 188:2  <b>1272</b> [2] 240:25 241:20</p>	<p><b>12th</b> [2] 51:6 69:10  <b>13</b> [18] 21:17 29:9 30:3,8      30:20 31:17,19,25 32:10      32:11 35:16 129:13      130:23 133:3 151:21      157:2 228:2,7  <b>132</b> [1] 378:23  <b>1373</b> [1] 365:21  <b>13th</b> [1] 393:19  <b>14</b> [3] 14:12,18 386:14  <b>142</b> [2] 376:21,24  <b>1420</b> [1] 245:3  <b>1447</b> [2] 8:10 29:5  <b>14th</b> [1] 394:6  <b>1538</b> [1] 259:11  <b>15th</b> [5] 68:7 185:19      198:7 202:2 210:10  <b>16</b> [2] 366:5 386:14  <b>16th</b> [10] 14:9 96:17      109:20 112:8 113:17      203:12 211:25 221:25      223:8 413:7  <b>17</b> [1] 360:19  <b>176</b> [4] 15:13 18:11 43:2      46:23  <b>177</b> [1] 286:17  <b>17th</b> [2] 17:15 36:5  <b>18</b> [2] 403:20 410:4  <b>1852</b> [1] 225:16  <b>18th</b> [10] 20:12 28:16,18      70:9 224:3,16 225:4      237:24 413:6 442:12  <b>1996</b> [1] 333:1  <b>1997</b> [2] 279:21 419:3  <b>1998</b> [3] 377:5 384:23      431:23  <b>1999</b> [5] 62:12,13 74:14      210:3 408:12  <b>19th</b> [4] 97:23 245:4      346:9 437:21  <b>1st</b> [3] 197:20 249:21      403:22</p> <hr/> <p style="text-align: center;"><b>-2-</b></p> <p><b>2</b> [2] 371:3,5  <b>2/2</b> [1] 148:5  <b>20</b> [9] 62:13 262:13 371:5      372:25 380:8,20,21 404:2      409:4  <b>2000</b> [4] 417:9,10,11,12  <b>2001</b> [2] 227:8 432:23  <b>2003</b> [2] 262:15 436:23  <b>2004</b> [10] 262:17,23 263:4      264:15 279:21 318:1,1      318:21 365:23 419:3  <b>2005</b> [52] 36:4,5 41:5      62:15 65:15 66:21 124:6      136:17 197:20 234:7,9      235:3,8 237:22 239:14      240:20,22 241:4,7 242:25      242:25 243:10,12,13,22      263:24 268:16 271:3      279:22,22 280:14 309:10      315:4 320:22 322:9</p>	<p>341:17 356:13 395:19      397:7,22 400:2 403:22      407:1 408:25 409:2,5      410:5 428:15,17 437:21      441:7 442:12  <b>2006</b> [48] 4:16 10:6 26:13      28:18 44:1 61:23 64:4      68:1 69:1,7,9 74:9 75:3      83:19 95:3 97:23 106:17      109:23 110:6,10,11      114:14 115:5 121:18      127:19 137:9 143:22      153:15 168:21 185:19      187:14 188:11,23 189:10      193:20 194:2,8,8 199:3      203:12 237:20 238:2      345:23,23 360:19 366:5      370:20 376:24  <b>2007</b> [49] 56:18 109:11      109:14,20 110:10,25      111:15 112:8 126:14      193:16,17 198:7 199:10      202:2 205:5 207:15      210:10 211:6,25 218:3      220:12 221:25 223:9      224:15,16 225:18 230:6      231:13 232:2 234:4      236:19 237:25 238:13      244:1,7,20 245:4 252:6      252:18 264:13 383:1      393:19,21 394:6 395:2      412:23 413:1,8 415:2  <b>2008</b> [13] 1:4 28:16 51:6      197:4 261:6 265:12      266:23 345:22 405:19      420:24 421:16 458:5,12  <b>208</b> [2] 13:23 14:4  <b>20th</b> [2] 36:4 95:4  <b>2157</b> [1] 286:3  <b>21st</b> [2] 95:9 115:5  <b>22</b> [29] 1:4 21:6,22 24:7      24:18 25:5 26:1,8,8,12      27:17,25 28:5,7,19 29:18      32:14 33:4 34:18 35:4      36:11 37:1,8 38:21 40:9      45:6,20 46:2 387:23  <b>22nd</b> [2] 458:5,12  <b>239</b> [1] 378:23  <b>23rd</b> [3] 127:19 165:18      252:18  <b>24</b> [2] 412:23 415:2  <b>24th</b> [2] 254:6 413:8  <b>25</b> [6] 143:12 262:13      375:21 376:25 383:15      408:15  <b>25th</b> [4] 188:4 194:16      244:1,7  <b>2633</b> [1] 265:6  <b>26th</b> [3] 74:9 83:19      193:16  <b>2700</b> [3] 170:22,23 171:4  <b>271</b> [2] 2:3,4  <b>2760</b> [1] 140:25  <b>277</b> [2] 2:4,5  <b>27th</b> [3] 68:8 409:2      415:10  <b>28</b> [6] 13:20 134:14 135:9</p>	<p>148:11,17 150:10  <b>287</b> [1] 51:6  <b>29</b> [2] 225:23 226:1  <b>2949</b> [1] 317:5  <b>295</b> [1] 3:2  <b>29th</b> [1] 68:1  <b>2:25</b> [1] 211:19  <b>2nd</b> [1] 440:6</p> <hr/> <p style="text-align: center;"><b>-3-</b></p> <p><b>3</b> [4] 315:6 316:11 365:21      453:15  <b>30</b> [9] 143:12,13 348:19      360:2,10 408:15 417:9      417:11 451:17  <b>300</b> [1] 164:12  <b>3039</b> [2] 4:11 6:16  <b>3042</b> [1] 8:3  <b>3053</b> [1] 127:13  <b>3054</b> [3] 129:22,25      134:18  <b>3056</b> [1] 129:24  <b>3057</b> [1] 131:24  <b>3067</b> [4] 413:20,22,22      414:5  <b>30th</b> [4] 110:11 224:14      440:1,2  <b>31</b> [1] 37:17  <b>314</b> [1] 132:5  <b>317</b> [4] 176:17 177:2,7      212:23  <b>31st</b> [2] 231:13 232:2  <b>341</b> [2] 134:23 135:8  <b>3439</b> [1] 259:24  <b>3468</b> [3] 295:5 415:1      425:23  <b>369</b> [1] 143:1  <b>388</b> [2] 2:5,6  <b>39</b> [2] 14:11,17  <b>391</b> [2] 346:10 347:24  <b>395</b> [1] 350:3  <b>3:30-4:00</b> [1] 247:12  <b>3rd</b> [2] 200:24 257:15</p> <hr/> <p style="text-align: center;"><b>-4-</b></p> <p><b>4</b> [1] 2:3  <b>40</b> [8] 62:16 143:14      209:13 360:10 365:24      380:8 388:19 422:16  <b>40-50</b> [1] 378:10  <b>413</b> [1] 378:23  <b>422</b> [1] 42:20  <b>424</b> [1] 240:11  <b>425</b> [2] 2:6,7  <b>436</b> [2] 377:22,25  <b>455</b> [2] 2:7,8  <b>457</b> [1] 2:8  <b>472</b> [1] 233:25  <b>4:30</b> [2] 93:19 247:17  <b>4th</b> [10] 61:22 62:15 64:4</p>	<p>65:15 66:21 69:1,9      231:22 232:10 249:22</p> <hr/> <p style="text-align: center;"><b>-5-</b></p> <p><b>5</b> [3] 143:4,11 376:24  <b>50</b> [6] 209:14 228:12,15      262:22 380:8 409:3  <b>50/60</b> [1] 373:12  <b>500</b> [1] 282:14  <b>52</b> [2] 131:18,19  <b>56</b> [2] 14:4 403:19  <b>59</b> [3] 418:18 419:3,25  <b>5th</b> [3] 205:15 252:6      265:12</p> <hr/> <p style="text-align: center;"><b>-6-</b></p> <p><b>60</b> [6] 143:15 262:21,22      377:25 378:3 451:18  <b>60-70</b> [1] 378:19  <b>61</b> [2] 373:10,15  <b>615</b> [3] 380:12,19,21  <b>68</b> [1] 380:19  <b>6:15</b> [1] 457:20  <b>6th</b> [4] 69:6 95:3 205:5      207:15</p> <hr/> <p style="text-align: center;"><b>-7-</b></p> <p><b>70</b> [1] 262:21  <b>717</b> [1] 378:2  <b>74</b> [5] 416:6,16 419:23      422:2 425:16  <b>75</b> [2] 371:5,13  <b>75.8</b> [1] 426:16  <b>763</b> [1] 132:23  <b>767</b> [1] 378:8  <b>778</b> [1] 380:7  <b>7th</b> [5] 44:1 137:9 143:22      157:15 234:4</p> <hr/> <p style="text-align: center;"><b>-8-</b></p> <p><b>80</b> [1] 326:19  <b>80/20</b> [1] 326:6  <b>804</b> [1] 378:23  <b>827</b> [1] 378:18  <b>835</b> [1] 240:11  <b>85</b> [1] 326:19  <b>887</b> [1] 381:21  <b>8th</b> [1] 75:3</p> <hr/> <p style="text-align: center;"><b>-9-</b></p> <p><b>9</b> [11] 30:3,8,10 32:10,11      35:17 129:13 130:24      364:23 365:6 386:14  <b>90</b> [7] 62:16 143:12,15      151:24 348:17,19 451:18  <b>923</b> [2] 42:2,17  <b>939</b> [12] 22:1 41:22 46:16      46:20,24 61:9 129:5      132:23 140:24 171:4      240:19 243:16</p>
---	--	--	--	---

**Inquiry on Hormone Receptor Testing**

<p><b>95</b> [6] 326:12 328:19 329:2 330:24 333:3 335:12</p> <p><b>962</b> [4] 83:6,17,21 84:20</p> <p><b>9:30</b> [1] 457:19</p> <p><b>9:31</b> [1] 414:23</p> <p><b>9:40</b> [1] 414:23</p>	<p>153:15 162:10 170:7 238:7 241:5 243:13 270:8 318:4 381:21</p> <p><b>accurately</b> [1] 150:5</p> <p><b>acknowledge</b> [3] 379:2 379:8 390:13</p> <p><b>acronyms</b> [1] 434:20</p> <p><b>act</b> [4] 116:2 206:20 302:9 446:9</p> <p><b>acted</b> [3] 239:15 303:19 409:18</p> <p><b>action</b> [33] 1:13 19:15 21:25 22:20,21 23:8,22 43:23 45:2 46:19 47:6 55:3 58:1 89:12 106:9 115:25 136:13 166:10 174:1 203:6 219:7 245:8 246:2,16 292:13 308:12 337:24 396:17 438:9 439:21 442:8 444:13,15</p> <p><b>actions</b> [7] 22:23 102:18 136:17 285:18 290:10 292:14 455:25</p> <p><b>activities</b> [3] 320:25 430:21 432:2</p> <p><b>actual</b> [10] 52:18 63:17 155:16 201:5 325:13 333:14 391:16 434:11,22 447:13</p> <p><b>ad</b> [2] 238:18 284:17</p> <p><b>adapt</b> [1] 306:21</p> <p><b>add</b> [7] 148:17 150:16 202:11,12 261:25 329:4 417:13</p> <p><b>added</b> [4] 5:8 24:24 65:16 240:8</p> <p><b>addendum</b> [4] 62:14 65:15 67:2 264:1</p> <p><b>adding</b> [1] 218:21</p> <p><b>addition</b> [4] 57:12 310:9 434:11 441:18</p> <p><b>additional</b> [1] 89:22</p> <p><b>address</b> [6] 7:1 69:18 103:2 107:5 286:15 402:11</p> <p><b>addressed</b> [5] 7:9 181:22 309:1 382:25 383:5</p> <p><b>addresses</b> [2] 245:24 247:7</p> <p><b>addressing</b> [1] 332:16</p> <p><b>adequate</b> [1] 348:21</p> <p><b>ADJOURNED</b> [1] 211:20</p> <p><b>adjust</b> [1] 293:21</p> <p><b>adjuvant</b> [2] 33:21 34:5</p> <p><b>administrative</b> [2] 267:15 403:20</p> <p><b>admit</b> [2] 213:2 223:18</p> <p><b>adopt</b> [1] 308:16</p> <p><b>adopted</b> [4] 352:10 355:1 356:18 400:2</p> <p><b>adopting</b> [2] 118:2 351:4</p> <p><b>ads</b> [1] 235:22</p> <p><b>advance</b> [4] 47:12 295:23 304:15 307:24</p>	<p><b>advanced</b> [1] 442:5</p> <p><b>advantage</b> [1] 314:8</p> <p><b>advantageous</b> [1] 304:15</p> <p><b>advantages</b> [2] 306:12 308:14</p> <p><b>adverb</b> [1] 27:22</p> <p><b>adverse</b> [14] 278:12,19 279:2,5,12,24 334:14 389:8,15 390:3,10 400:3 404:2,6</p> <p><b>advise</b> [19] 181:6,17,18 182:12,14 183:3 199:5 201:17 219:9 220:9 347:11 396:3,4 398:5 416:18 438:15 444:22 445:3,8</p> <p><b>advise</b> [5] 343:24 344:11 344:17 348:14 351:2</p> <p><b>advised</b> [9] 45:6 62:25 119:17 205:23 212:13 342:7 383:22 408:21 425:15</p> <p><b>advises</b> [2] 13:24 24:7</p> <p><b>advising</b> [4] 19:18 209:25 273:24 332:13</p> <p><b>Advisory</b> [2] 116:23 117:2</p> <p><b>Advocate</b> [1] 10:2</p> <p><b>advocating</b> [1] 221:15</p> <p><b>affect</b> [3] 273:4 275:1 372:16</p> <p><b>affected</b> [4] 201:6 239:10 453:9,17</p> <p><b>affects</b> [1] 432:17</p> <p><b>affidavit</b> [28] 185:15,18 185:21 186:1 187:15 199:9,12 200:6,13 202:10 202:21 203:18,21 204:7 204:9 212:24 224:6,7 225:25 415:22,23 419:16 419:24 420:3,8 425:12 425:14 426:21</p> <p><b>affiliated</b> [1] 342:13</p> <p><b>afternoon</b> [12] 78:25 98:1 103:17 139:19 211:24 267:23 271:25 277:16,24 278:2 293:10 293:23</p> <p><b>afterwards</b> [1] 184:24</p> <p><b>again</b> [61] 17:14,24 18:7 20:22 33:12 36:4,25 39:17 42:23 45:3 66:13 77:5 110:1,23 111:3,12 129:18 130:1 133:9 134:18 135:7,7 142:2 166:3 172:7 185:2 186:23 187:2,24 202:1 215:16 215:21 226:6 238:12 256:21 267:13 275:16 283:4,5 285:4 302:1 341:16 343:19 349:6 350:4 362:19 365:2 369:17 377:9 378:2 379:14 380:22 381:2 383:5 388:1 390:6 425:4 441:25 446:18 456:5,17</p>	<p><b>against</b> [9] 86:15 298:4 319:24 339:12 396:5,8 427:19 429:13 434:5</p> <p><b>age</b> [1] 209:13</p> <p><b>aggressive</b> [1] 184:15</p> <p><b>ago</b> [3] 204:21 295:16 455:22</p> <p><b>agree</b> [18] 38:2 67:8 250:19 282:6 283:18 300:13,21 307:22 310:20 314:14 317:21 338:11 379:25 382:16 397:6,9 397:17 451:1</p> <p><b>agreed</b> [10] 116:21 176:12 177:4,9 179:15 268:19,25 348:19 455:17 456:10</p> <p><b>agrees</b> [2] 212:4,25</p> <p><b>ahead</b> [8] 167:10 203:14 259:9 261:17 400:18 422:22 442:6 443:20</p> <p><b>aim</b> [2] 428:23 429:1</p> <p><b>al</b> [1] 1:9</p> <p><b>alarming</b> [1] 99:19</p> <p><b>alarmist</b> [6] 98:4 99:10 99:13 100:5,21 101:9</p> <p><b>albeit</b> [1] 350:7</p> <p><b>alert</b> [2] 304:6,8</p> <p><b>alive</b> [1] 243:17</p> <p><b>all-inclusive</b> [1] 25:6</p> <p><b>allegations</b> [1] 212:16</p> <p><b>allow</b> [1] 284:5</p> <p><b>allows</b> [1] 286:14</p> <p><b>almost</b> [4] 112:16 192:22 192:23 355:2</p> <p><b>alone</b> [1] 137:15</p> <p><b>along</b> [16] 13:7 26:18 45:5 60:14 88:23 135:15 151:18 250:6 256:20 291:9 327:25 333:21 374:21 420:12 450:7 452:21</p> <p><b>alternate</b> [1] 349:3</p> <p><b>alternative</b> [1] 456:6</p> <p><b>Alternatively</b> [1] 30:4</p> <p><b>always</b> [31] 25:16,16,18 45:24 72:22 91:15 98:3 99:8 101:12,16 106:10 155:2 163:21,22 166:21 236:10 239:7,13 251:3 251:13 256:12 280:16 284:1 291:14 421:1,24 424:17 430:8,18 441:25 452:17</p> <p><b>ambiguous</b> [1] 367:18</p> <p><b>American</b> [1] 432:12</p> <p><b>among</b> [3] 30:4 95:7 431:15</p> <p><b>amongst</b> [6] 32:14 41:3 146:13 259:25 394:7 416:4</p> <p><b>amount</b> [1] 39:19</p> <p><b>analogy</b> [1] 205:24</p> <p><b>analysis</b> [28] 61:10 70:15 152:17,18 153:7 155:3</p>	<p>155:17 297:20 307:22 338:16 358:1,8,20 360:1 360:7 364:3 372:22 374:8 380:15 382:17 432:16,17 433:18,19 449:23 450:9 450:13 452:6</p> <p><b>analytic</b> [1] 228:4</p> <p><b>analyze</b> [1] 434:23</p> <p><b>analyzed</b> [1] 360:6</p> <p><b>announcement</b> [3] 56:18 439:9 441:18</p> <p><b>annual</b> [3] 92:9 291:18 357:1</p> <p><b>answer</b> [30] 7:7 24:16 26:17 30:12,13,20 32:3 89:9 225:22 226:24 228:24 229:10,15 233:1 241:5 253:24 349:13,16 350:2 385:7 400:16 404:16 413:7,24 414:1,2 414:12 417:1 430:16 455:16</p> <p><b>answered</b> [2] 252:3 400:14</p> <p><b>answering</b> [3] 226:11 227:14 358:3</p> <p><b>answers</b> [17] 7:22 186:6 224:8,10,14 225:10,24 228:7 230:6 231:7 232:13 232:18 233:11 268:4 429:23 453:3,14</p> <p><b>antagonistic</b> [1] 184:14</p> <p><b>antenna</b> [1] 275:11</p> <p><b>antibodies</b> [5] 231:21 231:23 233:4,14,15</p> <p><b>anticipate</b> [10] 83:2 89:5 98:16 186:19 292:10,18 293:17 390:9 453:7,15</p> <p><b>anticipated</b> [2] 186:14 400:9</p> <p><b>anticipates</b> [2] 70:15 102:6</p> <p><b>anticipating</b> [1] 298:11</p> <p><b>anticipation</b> [2] 399:17 403:4</p> <p><b>antigen</b> [1] 228:6</p> <p><b>anxiety</b> [2] 352:1 356:14</p> <p><b>anxious</b> [3] 350:14 351:10 455:24</p> <p><b>anxiously</b> [1] 352:4</p> <p><b>anyhow</b> [2] 196:2 260:20</p> <p><b>anyway</b> [4] 101:16 126:25 279:18 359:22</p> <p><b>apart</b> [1] 133:17</p> <p><b>apologize</b> [1] 314:2</p> <p><b>apparatus</b> [1] 458:10</p> <p><b>apparent</b> [1] 370:12</p> <p><b>appealed</b> [1] 201:10</p> <p><b>appear</b> [7] 10:4 43:8 92:20 212:15 351:8 370:8 379:20</p> <p><b>Appearances</b> [1] 1:5</p> <p><b>applicability</b> [1] 280:12</p> <p><b>applicable</b> [4] 77:17 285:19 286:11 400:23</p>
---	---	---	---	--

**-A-**

**A's** [1] 171:25

**A.D** [2] 458:5,12

**a.m** [2] 213:9 414:23

**ability** [9] 153:14 209:6  
274:15 282:12 307:12  
308:21 365:2 431:1 458:9

**able** [53] 17:16 19:6 30:5  
32:13 34:19 35:3 44:15  
48:18,20 51:11 54:12  
64:8 66:6 68:13 117:14  
118:8,13,16 122:11  
127:20 153:21 158:5  
179:2 232:22 235:9  
241:15 262:4 268:4  
299:15 305:2,21 317:15  
317:22 319:24 321:20  
323:13,24 324:1,19  
342:18 357:6 358:18  
365:1,8 366:16 367:13  
383:4 394:18 406:21,25  
418:12 447:16,22

**abnormal** [1] 48:21

**abort** [2] 191:4,9

**above** [3] 20:11,13 229:5

**absence** [3] 282:6 283:19  
329:6

**absent** [3] 61:2 230:15  
230:18

**absolutely** [8] 19:23  
37:10 86:4 91:19 309:21  
373:3 398:2,7

**absorbed** [1] 319:3

**acceptable** [1] 85:13

**acceptance** [1] 85:13

**accepted** [3] 55:25 84:23  
447:3

**access** [6] 206:5,21,21  
208:7 209:7 342:14

**accommodate** [1]  
352:21

**accord** [2] 273:8 453:17

**accordance** [1] 291:9

**according** [7] 6:18 21:25  
81:19 349:15 352:8 353:5  
378:24

**accordingly** [1] 293:22

**accountability** [1]  
324:6

**accredit** [1] 52:8

**accreditation** [4] 428:6  
428:8 429:2 430:23

**accredited** [1] 49:14

**accuracy** [1] 153:2

**accurate** [14] 54:18  
99:23 142:9 146:24 153:9

<p><b>applicants</b> [2] 46:19 47:5  <b>application</b> [3] 304:20 326:7 420:16  <b>applied</b> [2] 142:1 401:16  <b>applies</b> [2] 282:14 402:2  <b>apply</b> [6] 276:8 281:19 283:23 314:14 400:2 404:5  <b>applying</b> [1] 281:21  <b>appointment</b> [10] 202:8 202:17 345:14 348:20 349:10,13 351:13 352:20 354:2 357:1  <b>appointments</b> [1] 348:25  <b>appreciate</b> [4] 210:13 210:15 452:24 457:10  <b>appreciated</b> [5] 89:22 90:4 218:5,9 234:11  <b>appreciation</b> [2] 124:8 125:8  <b>approach</b> [12] 346:1,7 347:6 351:4 352:10 355:1 355:2,18 356:18 376:4 449:11 452:13  <b>appropriate</b> [10] 76:3 114:8 116:15 119:15 120:1,11 142:8 342:19 344:11 382:17  <b>appropriately</b> [1] 410:8  <b>approval</b> [5] 13:6 17:25 54:3 117:5 289:13  <b>approve</b> [1] 20:14  <b>approved</b> [2] 248:21 288:18  <b>approximate</b> [1] 170:23  <b>April</b> [4] 8:4 200:24 231:22 232:10  <b>arbitration</b> [1] 10:5  <b>area</b> [14] 122:7 125:16 295:19 300:25 301:20 302:2,16 304:24 305:19 305:20 306:21,24 309:19 355:10  <b>areas</b> [16] 124:17 125:18 181:22 232:2 276:20 297:6,7 309:7 327:18 330:11 389:2 435:5,12 445:16,18 451:20  <b>arguing</b> [1] 415:15  <b>argument</b> [2] 415:3 423:15  <b>arise</b> [7] 185:2 234:11 298:3 331:14 338:12 390:3 391:6  <b>arises</b> [1] 296:1  <b>arising</b> [4] 269:19 454:5 454:8 455:7  <b>aromatase</b> [2] 156:11 156:22  <b>arose</b> [1] 284:2  <b>arrange</b> [1] 354:2  <b>arranged</b> [1] 102:16  <b>arranging</b> [1] 115:10</p>	<p><b>articulate</b> [1] 161:25  <b>articulating</b> [2] 162:4 176:21  <b>asap</b> [1] 231:15  <b>aside</b> [1] 446:8  <b>asks</b> [1] 14:1  <b>aspect</b> [3] 24:22 143:16 166:3  <b>aspects</b> [1] 309:18  <b>Assembly</b> [1] 165:24  <b>assert</b> [1] 71:13  <b>assertions</b> [1] 239:21  <b>assess</b> [1] 27:2  <b>assessment</b> [4] 430:24 434:21,25 436:13  <b>assessments</b> [2] 435:11 435:18  <b>assist</b> [5] 98:7 122:6 140:15 200:11 231:6  <b>assistance</b> [4] 366:24 367:4 434:13 454:20  <b>assistant</b> [2] 267:15 453:12  <b>assisted</b> [1] 27:6  <b>Association</b> [4] 1:14 431:24,25 432:13  <b>assume</b> [14] 8:24 14:21 53:11 63:1 83:1 124:20 165:9 194:21 224:18 233:9,10 276:11 281:6 299:13  <b>assumed</b> [1] 111:10  <b>assuming</b> [4] 11:22 153:11 271:2 381:20  <b>assumption</b> [1] 271:5  <b>assurance</b> [7] 119:20 123:6 320:25 321:14 323:4 446:14,22  <b>assurances</b> [2] 211:5 325:7  <b>ATIPP</b> [10] 197:14 198:6 198:18,23 200:11 206:16 206:23 207:17 208:23 209:17  <b>attached</b> [10] 4:17 8:15 20:11,13 136:8 137:1 224:5,8 246:17 417:2  <b>attaches</b> [1] 137:8  <b>attachment</b> [4] 129:21 130:2 413:1,14  <b>attempt</b> [5] 157:22 189:3 191:4 299:4 456:17  <b>attempted</b> [3] 191:9 241:11 243:19  <b>attempting</b> [1] 325:23  <b>attempts</b> [1] 189:10  <b>attend</b> [3] 171:23 183:19 310:23  <b>attendance</b> [2] 179:13 179:14  <b>attended</b> [2] 96:12 335:6  <b>attending</b> [1] 180:11  <b>attention</b> [8] 10:7,16,22 36:13 125:19 210:13</p>	<p>239:15 240:1  <b>attract</b> [1] 298:9  <b>attracts</b> [1] 300:19  <b>attribute</b> [3] 317:15,22 319:22  <b>attributed</b> [1] 313:22  <b>attributing</b> [2] 329:5 334:22  <b>audit</b> [13] 103:9,12,15 104:2,5,9 105:14 111:16 114:15,25 121:4 314:21 437:6  <b>auditing</b> [1] 125:15  <b>audits</b> [2] 121:22,23  <b>August</b> [19] 4:16 9:22 10:6 14:9 17:15 20:12 26:13 28:15,17 29:4 37:12 99:20 320:22 400:2 403:22 438:24 439:5,18 441:6  <b>authorities</b> [4] 1:17 272:2 277:9 314:17  <b>Authority</b> [1] 1:11  <b>automatic</b> [1] 300:20  <b>automatically</b> [2] 75:24 77:12  <b>avail</b> [2] 156:21 388:13  <b>available</b> [14] 19:18,21 47:14 55:6 192:11 250:21 264:9 318:21 348:20 350:24 353:8 407:15 449:24 450:24  <b>availing</b> [1] 307:25  <b>avenue</b> [1] 397:12  <b>average</b> [2] 416:6 425:16  <b>avoid</b> [3] 330:19 339:6 339:12  <b>avoidance</b> [1] 434:3  <b>awaiting</b> [1] 352:4  <b>aware</b> [62] 36:22 44:20 53:12 61:12 65:21 86:6 88:10,11 89:16 111:5,22 170:22 171:3 183:13 185:14,19 191:4,24 192:5 193:21 202:2 210:18 215:24 216:3 226:12,17 230:2,6 234:19 240:22 270:8 274:5,22 277:7 299:9 313:19 314:9 321:13 343:25 344:12 345:9 346:4 354:4,11,25 356:9,25 359:11 391:22 401:5,7,10 406:21 407:8 419:21 420:2,6,8,20 421:13,15 435:4  <b>away</b> [6] 26:1 237:24 238:4 252:11 406:16 433:3</p>	<p><b>balance</b> [1] 319:14  <b>Banerjee</b> [6] 179:1 194:1 226:18 230:13 342:10 445:14  <b>Banerjee's</b> [3] 230:24 243:25 244:8  <b>banged</b> [1] 398:13  <b>Barrington</b> [4] 70:10 70:21 129:19 189:21  <b>base</b> [1] 434:21  <b>based</b> [28] 5:18 22:23 35:19 52:23 53:3 54:5 54:20 61:8 84:16 148:1 148:3 149:13 155:14 170:11,18 184:4 221:4 299:11 337:16 360:20 363:16 366:10 367:10 370:8 371:18 419:14,15 421:18  <b>basic</b> [1] 454:18  <b>basis</b> [8] 22:19 47:6 158:6 275:3 283:24 284:18 285:13 308:13  <b>Battery</b> [1] 112:16  <b>bear</b> [1] 213:4  <b>bearable</b> [1] 91:13  <b>became</b> [9] 55:8 163:21 185:16 402:25 421:15 432:12 449:24 450:11 451:11  <b>become</b> [6] 46:19 47:5 232:3 388:14 420:6,20  <b>becoming</b> [1] 65:21  <b>beforehand</b> [3] 202:3 298:13 316:17  <b>begin</b> [2] 136:10 297:15  <b>beginning</b> [12] 7:1 8:6 11:10 24:11 45:10 46:1 121:8 186:2 228:22 385:11 428:22 452:5  <b>begins</b> [3] 74:8 234:2 429:24  <b>begun</b> [1] 317:12  <b>behalf</b> [5] 75:4 272:1 416:19 438:5 444:20  <b>behind</b> [4] 326:25 401:8 446:20 447:8  <b>belief</b> [1] 179:10  <b>believes</b> [2] 213:12 430:16  <b>below</b> [4] 61:20 240:8 379:22 429:11  <b>beneficial</b> [6] 111:25 311:3 312:8 313:18 314:24 395:24  <b>benefit</b> [4] 105:12 106:21 300:4 305:7  <b>benefits</b> [3] 19:3 306:3 391:20  <b>benign</b> [1] 48:14  <b>Bernard</b> [1] 1:6  <b>best</b> [15] 26:17 74:18 75:10 76:6 78:20 121:6 153:13 266:9 317:25 318:25 322:12,17 347:6</p>	<p>452:21 458:9  <b>better</b> [12] 46:4 118:21 118:22 213:8 218:19 283:9 318:11 320:5 342:19 343:6 376:20 398:4  <b>between</b> [37] 4:13,15 13:12 20:9 23:22 28:13 30:8 31:4 33:18 76:23 92:13 106:18 111:6 127:18 136:25 154:12 209:24 236:2 240:17 242:6,10 267:7 279:21 285:12 307:8 311:20,22 315:20 349:3 394:9 404:2 419:22 423:18 424:11 427:3 438:24 439:4  <b>Bev</b> [2] 97:24 99:8  <b>Bev's</b> [1] 98:3  <b>beyond</b> [4] 154:2 260:11 290:25 400:8  <b>big</b> [2] 308:21 331:8  <b>biggest</b> [2] 170:9 434:19  <b>Bill</b> [1] 212:7  <b>biochemistry</b> [2] 301:7 301:14  <b>biopsies</b> [1] 372:14  <b>biopsy</b> [3] 262:11,15 373:1  <b>biostatistician</b> [1] 450:19  <b>bit</b> [28] 47:23 98:4 99:10 99:19 100:20 106:11 142:4 148:21 180:23 184:13,15 199:17 203:8 215:21 236:22 262:3 278:7 286:5 292:23 306:14 325:11 330:10 334:17 353:3 410:4 431:20 436:11 451:13  <b>black</b> [3] 211:14 280:23 302:20  <b>Blair</b> [4] 1:16 2:4 271:23 271:25  <b>blame</b> [2] 331:23 332:2  <b>blank</b> [1] 7:2  <b>blocked</b> [1] 205:20  <b>blocks</b> [1] 378:15  <b>blood</b> [3] 48:17 209:13 303:6  <b>blue</b> [2] 240:8 343:15  <b>board</b> [11] 6:1 10:4 117:1 117:10 212:6,21 394:5 395:9,14 431:23 450:22  <b>Board's</b> [1] 431:24  <b>boards</b> [2] 433:2 435:22  <b>body</b> [2] 117:5 428:24  <b>bold</b> [2] 239:7 386:3  <b>bolded</b> [1] 129:7  <b>Bonnell</b> [37] 68:19 74:12 97:25 129:19 136:6 137:18 138:8,13 139:3 140:2,20 142:3 143:25 144:3,21,25 146:18 158:16,25 159:13 165:7 173:22 180:6 181:4 202:9</p>
---	--	--	---	---

**-B-**

**b** [2] 329:11,19  
**background** [8] 17:20 18:5 41:5,9 286:6 375:12 375:23 392:15  
**bad** [6] 9:2 126:6 212:14 293:20 335:19,21

<p>202:15 212:1 224:3,16 406:23 440:3,7 441:17 455:10,21,23 456:3 <b>Bonnell's</b> [2] 178:5 456:16 <b>book</b> [1] 260:15 <b>Boone</b> [17] 115:8,9 116:5 180:7,12 182:8 183:8 203:13 219:2,3,11 220:9 393:12 396:15 442:12,22 443:17 <b>bother</b> [1] 157:14 <b>bottom</b> [5] 51:7 210:1 242:9 381:20 426:7 <b>box</b> [2] 388:18 405:12 <b>Boyd</b> [1] 212:7 <b>brain</b> [1] 165:12 <b>break</b> [10] 127:16,16 133:24 134:2 209:21 277:16,19 293:5,11,23 <b>breakdown</b> [1] 28:24 <b>breaks</b> [2] 6:18 323:17 <b>breast</b> [11] 1:12 30:21 33:11 63:12 74:14 248:1 248:13 249:15 365:23 366:9 408:13 <b>brief</b> [2] 117:12 443:16 <b>briefing</b> [33] 4:15 5:25 8:12,15 10:9,14 12:1 13:17 14:20 20:14 21:6 21:23 28:18 42:4 43:18 44:22 47:20 54:21 55:7 96:20,25 128:23,24 132:1 135:25 136:10 146:1,8 165:23 168:22 172:3 173:15 186:23 <b>briefings</b> [5] 171:20 179:15 180:14 184:11,25 <b>bring</b> [18] 99:3 239:25 279:9,18 286:2,4 341:2 346:9 360:17 362:11 364:21 370:14 379:1 397:3 406:19 410:3 437:20 442:10 <b>bringing</b> [3] 5:3 419:16 456:24 <b>broad</b> [6] 99:16 101:25 233:19 389:23,25 450:19 <b>broader</b> [4] 199:16 307:18 374:12 389:11 <b>brochure</b> [2] 432:22 433:24 <b>broken</b> [1] 15:3 <b>Brook</b> [1] 62:3 <b>brought</b> [8] 4:24 125:19 140:10 145:19 268:20 286:7 433:6 456:11 <b>Browne</b> [3] 1:9 271:17 271:18 <b>budgets</b> [1] 433:2 <b>bug</b> [1] 406:5 <b>build</b> [1] 403:6 <b>bulk</b> [3] 221:8 222:3 246:21 <b>bullet</b> [5] 17:20,21 18:6 394:8,11</p>	<p><b>bunch</b> [1] 249:22 <b>business</b> [1] 455:10 <b>by/approved</b> [1] 37:23 <hr/><b>-C-</b><hr/><b>c</b> [4] 294:4 329:11,19 408:6 <b>C-0082</b> [1] 409:23 <b>C-0275</b> [3] 294:4,7,18 <b>C-0276</b> [5] 3:2 294:9,11 295:14 364:21 <b>Cabinet</b> [1] 38:1 <b>Cake</b> [2] 37:20 38:1 <b>calculate</b> [9] 85:16 149:1 150:16 151:19 152:10,14 153:22 155:13 158:5 <b>calculating</b> [2] 153:6 170:18 <b>calculation</b> [2] 170:10 170:10 <b>calculations</b> [4] 152:21 171:15 173:5,8 <b>calculator</b> [1] 147:18 <b>calls</b> [6] 235:5 236:2,9 252:1,4,8 <b>Cameron</b> [2] 1:3 458:6 <b>Canada</b> [1] 293:19 <b>Canadian</b> [4] 1:15 277:25 402:25 428:7 <b>cancer</b> [39] 1:12,15 30:22 33:11 34:11 48:20 49:2 60:5 62:12 63:12 74:14 76:19 90:10,15,21 91:1 91:5 188:19,21 189:6 190:2,7 195:4 196:10 210:2 248:1,13 249:15 251:5 262:18 266:9,12 267:7 278:1 310:19 355:3 365:23 366:9 408:13 <b>candidate</b> [4] 156:8 159:4 408:17,22 <b>cannot</b> [8] 30:2 62:18 115:22 135:19 151:6 157:21 187:10 430:17 <b>CAP</b> [8] 103:8 104:2,4,9 105:14 111:15 114:15,25 <b>capacity</b> [2] 424:8 427:24 <b>captured</b> [2] 32:22 37:8 <b>captures</b> [1] 242:18 <b>Carbonear</b> [4] 262:10 264:3,10,22 <b>carcinoma</b> [1] 262:17 <b>card</b> [1] 247:19 <b>cardboard</b> [1] 388:18 <b>cardiac</b> [1] 433:9 <b>care</b> [27] 60:5 117:9 136:25 181:5 188:21 190:2 239:14 263:19 278:6 279:2 281:5 313:11 338:6 342:14 389:20 402:23 419:7 422:21,23 423:1 430:17 431:16,24 432:13 435:16,20 447:4</p>	<p><b>careers</b> [1] 342:13 <b>carefully</b> [2] 254:16,21 <b>carried</b> [4] 102:10 123:20 193:9 296:16 <b>carry</b> [4] 121:9 144:10 192:16 426:15 <b>carrying</b> [1] 93:5 <b>Carter</b> [5] 97:24 99:9,11 103:8 123:23 <b>case</b> [22] 52:25 59:15 64:6 77:18 83:10 143:7 212:19 213:13 236:20 240:2 275:2,10 276:9 278:7 335:7 352:21 370:4 371:14 373:20 379:14 437:7 449:6 <b>cases</b> [16] 136:23 141:1,7 228:9,13 230:5,9,15,18 230:22 231:1 275:3 346:2 349:7 362:13 452:11 <b>catch</b> [4] 290:22 329:6 330:2 387:23 <b>categories</b> [2] 304:7 375:19 <b>categorize</b> [1] 46:3 <b>categorizing</b> [2] 31:12 33:24 <b>category</b> [16] 35:20 36:19 58:21 301:5 368:10 368:20 369:15,18,21 370:23 376:19 378:24 379:10,12,18 417:8 <b>Catherine</b> [1] 433:8 <b>caught</b> [4] 282:1 289:10 302:1 445:23 <b>causation</b> [1] 343:25 <b>causative</b> [4] 136:21 178:7,17 184:3 <b>caused</b> [7] 22:16,23 142:18 273:1 342:20 343:20,21 <b>causes</b> [1] 178:2 <b>caution</b> [1] 181:16 <b>CBC</b> [3] 173:23 174:5 206:5 <b>CCHSA</b> [7] 428:8,18,23 429:5,16 430:16,19 <b>cell</b> [2] 146:17 158:15 <b>central</b> [4] 1:16 272:2 276:19 406:9 <b>Centre</b> [7] 209:15 210:2 251:5 270:16 358:24 383:6 386:25 <b>CEO</b> [3] 222:10 393:24 394:4 <b>CEO's</b> [1] 394:6 <b>certain</b> [22] 9:14 52:15 59:18,24 79:20 99:21 100:8 154:3 175:20 216:7 217:15 225:24 230:15,18 253:18 291:6 301:2 304:3 330:10 395:14 402:24 432:11 <b>certainly</b> [36] 5:24 9:16 10:8 19:24 45:14 46:7 62:19 92:20 102:23</p>	<p>108:16 125:11 158:6 183:22 185:25 210:6 214:3,21 234:22 278:9 343:3 355:3,17 356:4,9 359:11 368:7,12 370:8 382:13 386:22 393:13 394:19 406:7 420:23 448:22 456:12 <b>certainty</b> [1] 220:25 <b>Certificate</b> [2] 2:9 458:1 <b>certification</b> [4] 213:12 393:20 415:4 420:15 <b>certify</b> [1] 458:2 <b>cetera</b> [3] 195:3 208:2 317:13 <b>chair</b> [2] 122:4 188:12 <b>chairs</b> [1] 394:6 <b>challenge</b> [2] 305:13 311:14 <b>challenging</b> [1] 304:24 <b>chance</b> [1] 42:25 <b>change</b> [85] 11:3 20:16 24:8 29:15,19 30:25 33:15 45:7 56:7 76:22 78:18 83:23,25 84:16 86:2 130:5,6 131:19 133:10 143:1,3,8,13,18 150:12 151:19,21,24,25 154:6,12,18 157:3 161:6 161:18,20 162:9,13 186:9 186:12 248:22 299:6 302:22 303:17,21 306:5 306:20 337:9,11 344:13 344:24 345:11 348:5,5 348:12,14,15,22 349:8 350:8,10 351:5,6,11 352:7,11,15,16 356:20 361:3 363:17 364:8 369:6 372:15 375:11 381:4,17 384:20 404:20 409:13,14 409:19 451:15,20 452:1 <b>changeable</b> [1] 306:18 <b>changed</b> [33] 13:22 29:10 56:14,20 57:14 59:15 76:22 77:21 82:12 131:14 148:20 155:11 164:13 174:18 175:2,4 188:10 210:6 236:15,18 248:18 263:9 280:7 300:19 301:2 301:12,23 344:12 350:7 404:21 423:24 439:14,15 <b>changes</b> [22] 4:17 5:7 8:24,25 14:7 24:9 29:2 42:21 45:8 132:4 133:16 133:18 149:11,12,19,20 149:24 150:9 155:14 293:17 344:15 351:14 <b>chapter</b> [1] 432:12 <b>characterize</b> [1] 438:20 <b>charged</b> [1] 247:18 <b>chart</b> [12] 6:18 17:23 65:14,16 67:3 69:20 205:25 206:5 207:1 209:8 262:5 384:24 <b>charts</b> [9] 31:3 33:17 35:9,13 195:4,5 196:10 196:11 355:7 <b>chat</b> [1] 208:1</p>	<p><b>Chaytor</b> [674] 1:7 2:3 4:2,4,5,10 5:5,12,17,22 6:9,15,22 7:6,14,21 8:1 8:9 10:12,19 11:2,12,16 12:2,9,18 13:1,10 14:23 15:7,12 16:1,10,21 17:1 17:8,12 18:15,25 19:8 19:14 20:1,7,25 21:8,16 21:21 22:6,12 23:3,19 24:1,5,23 25:9,24 26:11 26:25 27:5,10,16 28:4 28:11 30:17 31:9 32:2 32:12,20 33:2,9 34:13 35:1,7,15,21 36:1,16,24 37:5,11,16 38:8,13,17 39:12,25 40:5,13,19 41:1 41:12,18,25 42:6,15 43:6 43:13,19 44:12,19 45:1 45:16 46:9,15 47:4,22 48:5,11,24 49:6,21 50:2 50:11 51:3 54:24 55:14 61:15,16 63:18 64:2,7 64:22 65:5,11,19 66:2,7 66:14,19,25 67:23 68:17 68:22 69:23 70:3,7 71:2 71:8,12,17,21,25 72:4,9 72:16,24 73:8 74:1,6 76:5 77:4,14,25 78:10 78:23 79:4,9,23 80:5,16 80:21 81:12,20 82:4,14 82:20,25 83:16,22 84:1 84:19 85:6,14,19,23 86:5 86:11 91:7,8,24 92:4,12 92:18,23 93:16,25 94:4 94:10,16,21,25 95:14,18 95:24 96:11,15 97:4,13 97:20 99:2,7 100:3,9,13 100:18,24 101:6,17 102:4 102:15 103:1,24 104:3,8 104:13,17,23 105:19,24 106:14 107:1,8 108:9,20 109:5,10,18 110:5,9,16 110:22 111:4,13,19,23 112:7,20,24 113:3,7,16 113:24 114:7,13 115:3 115:14,20 116:13 117:11 117:24 118:7,14,25 119:6 119:13 120:7,15,20 121:16,24 122:8,23 123:9 123:14,18 126:1,12,21 127:2,12,15,17 128:4,11 128:15,21 129:3,11 130:9 130:14,21 131:4,8,17,23 132:11,15,21 133:8,15 133:22 134:4,5 135:5,14 135:22 136:4 138:6,11 138:18 139:2,8 140:1,14 140:19,23 141:6,12 142:6 142:16 143:20 144:19,24 145:6,12,21 146:5,11 147:5,10,20 148:10,15 149:2,9,16,25 150:7,15 150:22,24 152:20 153:10 153:19 154:20 155:18,22 156:19 157:1,7,11,25 158:10,14,19 159:7,12 159:19,25 160:7,15,20 160:25 161:4,14,24 162:5 162:17,23 163:12,18 164:3,9,20,25 165:5,15 165:21 166:3,7,16,22 167:1,14,19 168:8,13,19 169:3,9,13,20,25 170:12</p>
--	--	--	---	--

<p>170:20 171:2,9,19,24 172:4,9,13,18,23 173:13 173:18 174:4,10,17,22 175:3,8,12,19,24 176:7 176:15,20 177:1,6,11,21 178:3,12,16,22 179:6,11 179:18,25 180:5,10,18 181:10 182:4,16,20 183:6 183:12,17,25 184:9,22 185:9,13 186:3,15,20 187:7,13,20 188:1 189:9 189:18 190:5,10,23 191:2 191:13 192:4,9,15,20 193:2,7,14,25 194:6,13 194:20 195:20 196:1,7 196:15,20,24 197:3,7,12 197:18,24 198:5,13,21 199:1,8 200:2,7,16,20 201:24 202:23 203:3,10 203:24 204:8,17,25 205:9 205:13 206:11 207:14 209:2,18,21,23 210:22 211:4,10,16,22,23 214:11 215:2,10 216:5,11,20 217:1,13,23 218:6,10,16 219:1,8,16,21 220:1,6 220:18 221:11,23 222:10 222:14,19 223:7,15,21 224:1,13,21 225:2,9,15 225:21 226:10,16,23 227:18 228:1,18,23 229:6 229:12,16,21,25 230:12 230:19 231:5,11 232:12 232:17,21 233:2,24 234:18,23 235:13,17,21 236:25 237:4,9,15 238:11 238:16,22 239:2,6,24 240:5,24 241:13,19 242:5 242:15 243:6,23 244:5 244:11,19 245:2,12 246:23 247:3,21 248:5 248:10,16,23 249:2,8,13 249:19 250:12,23 251:19 251:23 252:15 253:6,12 253:23 254:3 255:4,8,12 255:24 256:10,17,23 257:8,13,24 258:4,14,19 258:25 259:5,10,18,22 260:13,18,25 261:4,16 262:1,8 263:2,10,18,23 264:5,23 265:3,10,16,20 265:24 266:3,15,20 267:3 267:10,16,20 268:8,12 269:5,10,17,24 270:11 270:20,25 271:6,11 272:7 272:21 273:13 287:25 294:12,17,24 411:10 413:3 428:6 445:15 454:5 454:6 457:4,5</p> <p><b>check</b> [17] 14:15 92:9 101:13,16 121:3,5,12 124:19 187:24 194:23 246:9 288:8,9,16 353:25 405:12 448:17</p> <p><b>checked</b> [2] 99:22 101:14</p> <p><b>checking</b> [1] 188:8</p> <p><b>checks</b> [3] 302:3 327:17 330:2</p> <p><b>cheese</b> [4] 328:8,14 331:3 333:15</p> <p><b>chemotherapy</b> [1]</p>	<p>408:14</p> <p><b>Ches</b> [2] 43:25 213:16</p> <p><b>Ches's</b> [1] 213:13</p> <p><b>Chesley</b> [3] 1:12 2:6 388:22</p> <p><b>chest</b> [1] 262:15</p> <p><b>chief</b> [2] 75:23 122:3</p> <p><b>chiefs</b> [2] 74:20 76:24</p> <p><b>Child</b> [1] 10:1</p> <p><b>choice</b> [2] 75:20 337:24</p> <p><b>choices</b> [1] 336:7</p> <p><b>chronology</b> [1] 262:4</p> <p><b>circulate</b> [1] 145:5</p> <p><b>circulated</b> [2] 142:5 144:11</p> <p><b>circulating</b> [1] 249:24</p> <p><b>circulation</b> [1] 403:8</p> <p><b>circumstance</b> [10] 112:23 113:23 125:12 303:16 333:12,13 334:12 336:20 351:16 353:11</p> <p><b>circumstances</b> [17] 143:6 190:21 258:10,15 261:7 284:4 291:13 302:19 328:2 333:11 337:3 340:24 342:5 384:17 385:3 411:3 450:21</p> <p><b>citing</b> [1] 201:8</p> <p><b>claim</b> [13] 43:24 44:10 47:8 163:16,24 166:5 169:1 391:5,18 392:9 393:4 424:2 427:19</p> <p><b>claim's</b> [1] 231:15</p> <p><b>claims</b> [14] 18:17,20 43:15 47:6 48:4 427:4 427:11,11 431:10 434:4 434:22,23 435:1,4</p> <p><b>clarification</b> [10] 14:6 16:4 213:18 220:20 221:13,14 222:21 225:24 312:1 319:20</p> <p><b>clarified</b> [1] 319:9</p> <p><b>clarifies</b> [1] 236:16</p> <p><b>clarify</b> [11] 16:23 17:16 26:4 205:6 207:16 220:17 240:10 253:5 279:8 383:12 455:9</p> <p><b>clarifying</b> [2] 212:5 213:1</p> <p><b>class</b> [12] 1:13 22:21 43:23 46:19 47:6 89:12 115:25 136:12 219:7 245:8 246:2,16</p> <p><b>classified</b> [2] 207:23 208:13</p> <p><b>classify</b> [1] 100:5</p> <p><b>clean</b> [1] 127:20</p> <p><b>cleaning</b> [1] 130:11</p> <p><b>clear</b> [18] 17:25 25:12 31:14,24 50:16 75:17 121:21 143:23 146:16 176:5 182:6 193:18 206:23 217:7,8 234:8 274:4 384:1</p>	<p><b>clearly</b> [11] 54:11 112:21 161:25 162:3 173:11,14 173:19 236:22 253:4 282:7 324:19</p> <p><b>client</b> [5] 74:19 75:11 76:7 430:9,14</p> <p><b>clinic</b> [17] 90:10,16 91:1 91:5 188:19 189:7 190:7 195:4 196:10 262:18 266:9,12 267:7 348:20 350:11 353:13 355:3</p> <p><b>clinical</b> [15] 74:20 75:23 76:24 142:25 146:23 147:4 148:1 151:6 152:22 153:22 170:19 266:11 357:11 370:9 379:22</p> <p><b>clinically</b> [4] 153:23 377:6 417:8,15</p> <p><b>clinician</b> [1] 374:13</p> <p><b>clinicians</b> [5] 33:22 76:24 78:19 366:20 374:10</p> <p><b>close</b> [2] 8:11 422:16</p> <p><b>clot</b> [1] 48:17</p> <p><b>Co-counsel</b> [2] 1:6,7</p> <p><b>co-ordinator</b> [1] 436:7</p> <p><b>coffee</b> [3] 215:23 217:25 218:7</p> <p><b>Coffey</b> [3] 1:6 366:23 367:14</p> <p><b>cognizant</b> [2] 22:25 154:22</p> <p><b>cold</b> [1] 98:19</p> <p><b>collated</b> [2] 70:14 452:15</p> <p><b>colleague</b> [1] 400:15</p> <p><b>colleagues</b> [2] 212:10 349:25</p> <p><b>collection</b> [2] 324:11 452:10</p> <p><b>colour</b> [1] 30:19</p> <p><b>column</b> [3] 350:4 418:6 418:17</p> <p><b>combination</b> [3] 421:2 421:22,25</p> <p><b>combined</b> [1] 91:16</p> <p><b>comfort</b> [7] 163:5,10,13 166:4 168:17,24 404:10</p> <p><b>comfortable</b> [6] 40:6 40:20 56:25 114:21 386:20 447:16</p> <p><b>coming</b> [16] 26:12,16 27:6 36:11 67:4 111:14 140:15 147:16 154:25 181:15 266:21 272:17 273:3 346:12 383:7 457:10</p> <p><b>comment</b> [11] 77:8,10 99:20 114:24 168:5 200:1 213:9 218:19 222:12 366:16 394:18</p> <p><b>commented</b> [1] 399:18</p> <p><b>commenting</b> [1] 202:22</p> <p><b>comments</b> [8] 13:24 26:19 98:3 99:9 100:2,4 101:20 212:11</p>	<p><b>commercial</b> [1] 434:12</p> <p><b>Commission</b> [7] 1:1,6 1:7 270:1 407:13 458:4 458:7</p> <p><b>commissioned</b> [1] 401:3</p> <p><b>Commissioner</b> [126] 1:3 2:8 4:1,6 55:16,23 56:6 56:21 57:3,10,17,24 58:6 58:12,18,24 59:4,13,21 60:7,11,17,22 61:14 67:7 67:13 73:10,18,24 86:17 86:23 87:10,19 88:1,5 88:13,21 90:2,8,14,24 91:6 119:9 124:2,23 125:4 127:14 133:23,25 134:3,6 151:1,10,14 152:4 181:23 182:22 191:18 192:2 200:19 201:11 209:20 211:17,18 211:21 233:12,18,22 271:10,13,16,21 277:14 293:4,9,25 294:3,6,10 294:15 295:3,8 328:24 329:10,16 346:11,24 347:10,16,21 387:8,15 387:19,24 388:5,10,20 391:25 402:15 407:16,17 407:22 408:1,5,10 409:9 409:24,25 418:11 421:4 422:17 424:23 446:17 447:7 454:4,7,12,17 455:5,6,15 456:20 457:2 457:7,18 458:7</p> <p><b>Commissioner's</b> [3] 201:14 203:14 205:19</p> <p><b>committee</b> [11] 116:23 117:10 123:6,24 205:17 231:18,18 232:23,24 292:1,25</p> <p><b>Committee's</b> [1] 117:3</p> <p><b>committees</b> [1] 291:24</p> <p><b>communicate</b> [5] 274:11 324:19 345:12 443:13,23</p> <p><b>communicated</b> [13] 40:1 58:8 173:11,19 195:18 221:6,8,9 302:24 311:1 439:7 443:12 444:3</p> <p><b>communicating</b> [3] 249:25 274:14 443:18</p> <p><b>communication</b> [16] 7:17 39:23 96:18 146:13 210:25 223:3,9 233:13 261:22 277:8 321:7 341:9 342:16 345:15 376:9 396:24</p> <p><b>communications</b> [3] 132:18 158:3 340:25</p> <p><b>compare</b> [1] 155:15</p> <p><b>comparison</b> [1] 206:4</p> <p><b>competency</b> [1] 259:2</p> <p><b>compile</b> [1] 253:2</p> <p><b>complained</b> [1] 195:3</p> <p><b>complete</b> [3] 142:22 231:16,25</p> <p><b>completed</b> [12] 14:13 49:15 70:16 103:21 106:1 106:3,18 108:8 237:12</p>	<p>292:14 435:24 452:11</p> <p><b>completely</b> [1] 61:22</p> <p><b>completing</b> [2] 191:10 452:9</p> <p><b>complex</b> [4] 309:13 313:6 329:24 335:22</p> <p><b>complexity</b> [2] 310:9,21</p> <p><b>compliance</b> [2] 405:15 406:4</p> <p><b>complicated</b> [3] 260:24 280:25 370:4</p> <p><b>complicating</b> [2] 74:21 77:6</p> <p><b>component</b> [3] 330:3 389:25 390:14</p> <p><b>comprehensive</b> [4] 98:2 236:3 311:4 360:22</p> <p><b>compromised</b> [1] 273:1</p> <p><b>computer</b> [3] 198:20 227:8 264:9</p> <p><b>computers</b> [1] 199:6</p> <p><b>concede</b> [1] 124:25</p> <p><b>concentrate</b> [1] 160:9</p> <p><b>concept</b> [2] 272:23 430:13</p> <p><b>concern</b> [59] 51:20 52:11 60:25 83:8,13 98:20,25 102:21 103:3 107:25 120:21 125:11 139:4 142:19 143:14,15 146:19 147:11,12 149:4 150:5,8 156:15 162:6,10 163:4 163:14 169:21 170:5,9 170:17,18 171:11,12 173:2,5,10 195:22 196:2 196:6 238:7 239:21 276:21 307:18 346:18 350:5,12 352:22 353:18 353:22 356:13 377:18 379:21,25 392:17,19 394:12 430:19 446:11</p> <p><b>concerned</b> [18] 75:20 99:17 101:3,4,7 102:2 107:16,23 144:12,16 147:14 148:16 170:13 196:5 249:15 315:14,24 373:24</p> <p><b>concerning</b> [8] 143:11 347:2 421:10 436:19,20 438:7,9 440:4</p> <p><b>concerns</b> [25] 64:24 108:13 126:10 127:4 137:2 141:1 145:19 148:21 158:5,24 160:16 160:19,23 169:14 204:10 206:1 212:8 232:1 261:11 292:22 321:7 374:12 407:4 437:23 454:8</p> <p><b>conclude</b> [1] 61:1</p> <p><b>conclusion</b> [4] 242:22 276:4 341:12 457:20</p> <p><b>conclusions</b> [2] 61:8 383:23</p> <p><b>concrete</b> [2] 250:8 451:12</p> <p><b>condition</b> [1] 101:1</p> <p><b>conducted</b> [3] 30:11</p>
--	--	--	--	--



<p>209:14 360:1  <b>conference</b> [6] 146:12                  206:15 207:4 432:11,22                  434:1  <b>conferences</b> [1] 433:4  <b>conferecing</b> [1] 293:15  <b>confidence</b> [3] 116:20                  116:24 447:23  <b>confidences</b> [1] 449:12  <b>confident</b> [5] 116:14                  119:15 120:1 144:1 149:5  <b>confidential</b> [1] 448:15  <b>confidentiality</b> [5]                  205:17 445:23 446:12,21                  447:8  <b>confined</b> [1] 443:4  <b>confirm</b> [8] 54:22 64:8                  188:17,25 190:14 198:7                  254:15 323:23  <b>confirmation</b> [4] 24:11                  45:10 191:5 198:9  <b>confirmed</b> [31] 13:21                  14:11,17 56:13 57:21                  134:11,14,16,20,21,23                  135:8,8,9 143:2,3,6                  148:13 150:10 191:6                  226:4 229:20 230:1                  236:12 332:14 334:24                  379:15 384:6,8 385:11                  407:5  <b>confirming</b> [2] 73:13                  399:14  <b>conflict</b> [3] 423:18,21                  424:11  <b>conflicted</b> [1] 397:24  <b>conforming</b> [1] 400:22  <b>confronted</b> [1] 212:9  <b>confused</b> [1] 348:17  <b>connection</b> [1] 231:3  <b>conscious</b> [1] 186:24  <b>consensus</b> [1] 387:9  <b>consent</b> [2] 207:8 208:21  <b>consequences</b> [2]                  444:21 445:7  <b>consider</b> [9] 89:25 250:9                  251:3,8,13 303:2 340:15                  392:8 438:16  <b>considerable</b> [1] 342:3  <b>consideration</b> [2] 257:6                  441:16  <b>considered</b> [24] 13:25                  30:22 31:1 33:12,16                  287:13 306:15,16 336:5                  361:5,14,20 364:17 366:6                  371:1,11 372:21 375:3                  376:14 383:18 384:25                  385:10 437:25 445:17  <b>considering</b> [2] 272:15                  452:5  <b>consistency</b> [2] 141:25                  320:4  <b>consistent</b> [14] 24:6,13                  186:25 275:9 312:4                  319:13 322:6 332:25                  352:9 355:19 372:1 382:2</p>	<p>426:20 430:5  <b>consistently</b> [2] 130:25                  379:24  <b>constant</b> [1] 91:11  <b>constitute</b> [6] 295:24                  297:2 302:15 304:18                  365:3,4  <b>constitutes</b> [2] 296:12                  299:13  <b>consult</b> [11] 26:14 32:5                  61:23 65:23 206:2,3                  259:6 395:18,20 397:13                  397:22  <b>consultant</b> [1] 57:7  <b>consultant's</b> [1] 51:19  <b>consultants</b> [4] 49:10                  52:18 53:6,13  <b>consultation</b> [4] 207:6                  208:5 341:1 451:8  <b>consulted</b> [3] 38:25                  205:22 449:22  <b>consulting</b> [1] 450:4  <b>consults</b> [1] 208:6  <b>Cont'd</b> [2] 2:3 4:4  <b>contact</b> [45] 8:19 15:17                  58:3 59:9,14 60:5 68:3                  68:18 79:11 81:2 89:16                  93:1 114:9 189:6,11                  191:14,19,22,24 210:7                  222:16,22 223:10,13                  234:4 235:9 237:10                  241:11,16 243:19 245:19                  249:18 254:18,23 256:1                  266:16 267:9 268:2                  276:19 344:10 348:13                  354:10 389:19 407:8                  443:6  <b>contact/conversions</b>                  [1] 127:21  <b>contacted</b> [52] 69:5,25                  70:2,4,6,13,22 71:5,14                  72:18,20 73:4 74:3 75:1                  75:21 86:25 94:12 137:18                  188:15,24 189:3,13,22                  190:3,13 195:1,9 210:19                  211:7 222:5 234:6,9,15                  235:5 236:1,24 237:5                  238:5 239:11 240:19                  241:4,7 254:14 256:14                  257:2 258:9 259:8,9                  268:15 270:6 352:12                  386:21  <b>contacting</b> [9] 88:20                  94:17 210:11 257:10,21                  266:25 269:3,13 443:9  <b>contacts</b> [4] 72:13 92:1                  181:21 407:4  <b>containing</b> [1] 317:6  <b>contains</b> [1] 448:14  <b>contamination</b> [2]                  323:13 324:13  <b>contemplated</b> [1] 95:19  <b>contemplating</b> [1]                  256:24  <b>content</b> [6] 86:18 181:17                  246:10 247:22 280:7                  316:2</p>	<p><b>CONTENTS</b> [1] 2:1  <b>context</b> [9] 9:21 25:23                  80:14 81:11,14,16 189:24                  340:18 438:14  <b>continue</b> [6] 49:15 93:5                  145:3 181:19 347:12                  439:20  <b>continued</b> [3] 99:25                  169:4 266:23  <b>contributed</b> [4] 67:21                  333:21 344:1,2  <b>contributing</b> [2] 335:2                  342:4  <b>control</b> [10] 86:13,15                  226:5 229:11,11 230:2                  274:8 290:24 316:14                  330:9  <b>controls</b> [25] 86:7 226:1                  226:3,4,13,19,19,25                  227:3,7,13 228:4,8,11                  228:14,25 229:1,2,8,19                  230:4,8,15,21,25  <b>convenience</b> [1] 282:11  <b>convenient</b> [1] 293:6  <b>conveniently</b> [1] 282:12  <b>conversation</b> [22] 12:20                  17:19 23:16 31:14 39:6                  39:18 42:11 44:6 54:16                  54:20 63:14,25 64:17                  76:23 144:10 158:15                  218:22 242:10 243:15                  437:23 442:21 443:17  <b>conversion</b> [11] 148:7                  246:20 262:23 357:15                  364:17 366:13 368:10,15                  371:8 375:1 376:15  <b>conversions</b> [13] 141:22                  362:2 365:4 370:8,23                  376:20 378:21 380:7,11                  381:2,10,12 382:15  <b>convert</b> [1] 68:8  <b>converted</b> [11] 62:2                  129:6 130:5,8,16 133:9                  147:3 248:2 354:6 360:11                  383:15  <b>converter</b> [5] 74:25 76:2                  83:10 357:19 361:21  <b>converters</b> [12] 83:19                  84:2,18 357:7,8 360:17                  360:23 362:13 363:6                  364:3 366:20 370:16  <b>convertor</b> [2] 374:2                  375:3  <b>convertors</b> [4] 129:14                  147:2 150:20,20  <b>converts</b> [2] 364:16                  380:9  <b>conveyed</b> [1] 59:9  <b>convince</b> [1] 247:17  <b>Cook</b> [15] 50:22 97:25                  104:25 115:8 155:2                  200:23,23 232:20 268:18                  276:23 315:5,7,10 360:21                  450:8  <b>Cook's</b> [3] 318:15,23                  322:7  <b>cooperation</b> [1] 191:11</p>	<p><b>coordinating</b> [2] 98:9                  249:4  <b>copied</b> [6] 37:19 74:12                  80:17 244:24 252:17                  260:7  <b>copies</b> [5] 89:3 172:8                  194:2 203:13 453:14  <b>copy</b> [19] 8:14 20:11,13                  89:23 103:14 114:5                  194:10 225:11 232:10                  238:18,19,23 243:24                  244:6,8,16,18 245:1                  414:4  <b>copying</b> [1] 80:23  <b>core</b> [2] 372:14,25  <b>Corner</b> [1] 62:2  <b>Corp</b> [2] 402:23 419:7  <b>corporate</b> [7] 287:11,17                  288:13 290:12 291:10                  304:20 308:17  <b>corporate-wide</b> [1]                  285:14  <b>Corporation</b> [5] 278:6                  279:2 281:5 435:16,21  <b>correct</b> [21] 22:15 30:14                  41:22 54:22 56:3 59:10                  66:21 68:19 85:20 172:20                  189:1 235:8 241:8,21,25                  361:11 434:10 442:17                  445:3 446:10 458:3  <b>corrected</b> [1] 53:15  <b>correction</b> [1] 292:13  <b>corrective</b> [3] 285:17                  290:10 308:11  <b>correctly</b> [6] 70:21                  284:23 329:12,12,19                  427:8  <b>correspondent</b> [1]                  453:13  <b>Council</b> [2] 202:19 428:7  <b>counsel</b> [12] 19:17 47:15                  55:5 96:3 199:24 246:9                  249:1,1 293:11 433:10                  454:10,23  <b>count</b> [1] 415:14  <b>counted</b> [1] 411:6  <b>counter</b> [1] 395:2  <b>counterparts</b> [1] 276:19  <b>counting</b> [1] 422:7  <b>country</b> [2] 314:21                  434:22  <b>couple</b> [18] 90:19 134:18                  141:20 204:21 218:4                  285:17 305:16 307:5                  332:13 340:23 360:15                  362:10 376:19 380:6                  400:9 425:10 449:17,21  <b>courier</b> [1] 69:7  <b>course</b> [39] 6:17 9:11                  12:3 18:8 25:5 34:14                  55:2 78:6 83:7 99:23                  139:16 153:11 156:13                  165:12 191:23 193:21                  201:25 203:6 261:12                  352:22 353:5 355:12                  358:24 368:15 371:15</p>	<p>372:6 374:1 377:5,14                  383:5 387:13 393:20                  400:20 408:18 415:16                  437:4 438:9 439:21                  456:24  <b>court</b> [22] 136:22 166:13                  166:14 167:10,11 168:6                  174:2 185:7,10 204:10                  204:15 220:24 224:20                  245:9 246:1,5,15,15                  248:21 416:17 419:24                  420:4  <b>courts</b> [13] 163:25 167:4                  168:4 169:5 176:1,10,23                  177:12,16,24 178:19                  184:6 213:21  <b>cover</b> [3] 193:19 246:20                  290:17  <b>coverage</b> [12] 74:22 77:5                  212:3 213:3,24 214:5                  392:3,14,19 394:25                  397:25 434:12  <b>covered</b> [2] 193:10 451:3  <b>covering</b> [2] 214:18                  215:6  <b>cracks</b> [2] 65:7 67:16  <b>create</b> [1] 359:18  <b>creating</b> [1] 396:17  <b>credit</b> [1] 247:18  <b>crisis</b> [3] 397:5,7,11  <b>criteria</b> [14] 25:22 28:21                  47:7 67:10 91:4 261:13                  269:1,23 288:21 360:2,5                  368:12 429:9,11  <b>critical</b> [6] 278:10 281:6                  301:25 436:25 437:3,4  <b>Crosbie</b> [124] 1:12 2:6                  43:25 83:1,11 294:13                  295:4,6 388:11,12,22,23                  389:5,17 390:1,12,18,23                  391:7,13,24 392:13,20                  393:11,16 394:3,21 395:5                  395:12,17 396:2,14,21                  397:1,10,16,20 398:3,8                  398:17,21 399:3,12,21                  399:25 400:13 401:9,15                  401:19,25 402:13 403:7                  403:18,25 404:15,19,25                  405:9,20,25 406:8,13,17                  407:10,19,24 408:3,8                  409:22 410:2,13,19,23                  411:4,11,16,21,25 412:6                  412:11,17,21 413:2,11                  413:17,21,25 414:6,11                  414:16,25 415:8,13,19                  416:1,10,25 417:16,22                  418:1,9,16,21,25 419:10                  419:20 420:5,9,14,19                  421:17 422:1,6,12,18,19                  423:2,6,11 424:6,19,24                  425:10,24  <b>cross</b> [3] 323:12 324:12                  418:17  <b>crossed</b> [2] 162:15,20  <b>Crowley</b> [13] 197:19                  200:22,24 203:12 205:2                  205:18 206:7 207:16                  245:4,18,21 247:6 248:20</p>
--	--	--	--	---

<p><b>Crowley's</b> [1] 246:13  <b>CT</b> [1] 320:11  <b>culture</b> [5] 306:5,6,9  394:11,15  <b>cup</b> [2] 215:22 217:24  <b>cups</b> [1] 218:7  <b>curious</b> [1] 385:23  <b>current</b> [10] 42:16 51:21  52:10 100:25 105:5 107:3  109:13 357:7 402:16  428:17  <b>cursor</b> [2] 341:6 379:12  <b>cut</b> [4] 30:13 112:17  206:24 379:23  <b>cutoff</b> [1] 370:11</p>	<p>335:21 424:3  <b>dealing</b> [9] 11:4 15:2  57:1 87:15 309:12 346:15  390:2 437:14 452:10  <b>dealings</b> [1] 249:9  <b>deals</b> [1] 284:10  <b>dealt</b> [5] 136:21 168:25  288:5 348:7 350:19  <b>Deanne</b> [1] 199:5  <b>death</b> [2] 333:12 334:15  76:13 77:2  <b>Debbie</b> [2] 129:23 244:4  <b>debilitation</b> [1] 334:15  <b>deceased</b> [49] 15:2,4  18:11 32:15,21 33:1,4  34:15 36:2,6,10,12,15  36:18,23 46:23 47:2  55:17,20 56:1,2 57:18  58:2,13 59:7 60:12 61:12  129:15 139:15 140:11  142:21,22 154:16,17  250:1,4 252:2,9 362:2,3  362:6,14 363:23 364:4  369:5 377:14 379:6 381:4  383:3</p>	<p>382:19 386:24 390:17  434:7 448:6  <b>definition</b> [3] 157:8,10  425:17  <b>definitive</b> [1] 72:21  <b>definitively</b> [1] 71:13  <b>delaying</b> [1] 439:8  <b>delays</b> [2] 283:7 398:23  <b>delete</b> [1] 134:25  <b>deleted</b> [1] 131:5  <b>deliberately</b> [1] 212:15  <b>delve</b> [1] 292:22  <b>denial</b> [1] 312:2  <b>Denic</b> [33] 8:17,22 12:11  50:9,22 64:9 74:10 95:6  96:2,18 97:6,8,25 105:1  108:16 114:9 115:8 122:2  165:9 184:17,19 200:23  200:25 358:11,14,17  359:8 360:20 363:11  370:16 376:23 380:24  408:16</p>	<p>42:18 51:1 62:4 64:19  213:20 220:23 221:10  304:16  <b>detect</b> [1] 431:1  <b>detected</b> [1] 408:24  <b>determine</b> [13] 32:13  118:8,13 122:11 152:18  179:3 182:1,25 193:3  329:18 336:12 390:9  400:22  <b>determined</b> [7] 31:3  33:17 153:23,25 162:12  178:24 432:4  <b>determining</b> [2] 151:5  425:18  <b>deterred</b> [1] 340:17  <b>develop</b> [2] 282:20 298:8  <b>developed</b> [6] 29:13 55:8  56:8 213:13 282:16 400:6  <b>developing</b> [3] 50:23  123:24 338:19  <b>development</b> [1] 123:25  <b>developments</b> [1]  231:14  <b>diagnosed</b> [8] 30:21 31:5  33:11 62:12 74:14 365:22  408:12,13  <b>diagnosis</b> [4] 75:17  131:11 262:16 264:15</p>	<p><b>directing</b> [2] 18:2 51:7  <b>direction</b> [16] 81:7 108:7  135:24 200:6 214:8,14  216:23 344:23 346:7,16  350:1 355:19 393:9 438:5  438:10 444:12  <b>directly</b> [9] 14:16 39:10  39:14,22 109:21 113:4  210:25 355:22 424:7  <b>director</b> [1] 60:4  <b>directory</b> [1] 18:3  <b>disagreement</b> [2] 291:2  311:20  <b>disappointed</b> [1] 53:18  <b>disappointment</b> [1]  342:6  <b>discharge</b> [1] 91:4  <b>discharged</b> [2] 90:18,22  <b>disciplinary</b> [1] 10:4  <b>disclaimer</b> [1] 272:15  <b>disclose</b> [16] 74:18 75:10  76:6 81:6 168:22 212:13  250:18 278:22 392:24,24  393:2,3 438:2,3 448:20  448:24  <b>disclosed</b> [10] 77:1 92:10  180:14 182:11 183:8  187:10 333:8 393:3,5  448:16</p>
<p><b>-D-</b></p>				
<p><b>d</b> [2] 329:11,19  <b>DAKO</b> [4] 319:11,13  418:18 426:15  <b>damages</b> [2] 47:9 330:19  <b>Dan</b> [6] 116:5 137:3  180:6,7 213:9,16  <b>danger</b> [1] 182:2  <b>Daniel</b> [3] 1:10 2:7  424:25  <b>dark</b> [1] 158:23  <b>dash</b> [1] 321:19  <b>data</b> [17] 61:1 127:20  132:24 135:17 153:21  358:19 359:5 370:12  371:5 378:25 379:16  383:9 419:13 421:13  450:9 452:10,14  <b>database</b> [10] 264:16  359:1,13,17,19 360:5,9  381:22 382:1,6  <b>datasheet</b> [1] 127:21  <b>date</b> [17] 44:9,13,16 96:7  116:18 145:24 187:18  227:6 242:6,16 246:22  270:7,8 360:23 412:12  413:4,7  <b>dated</b> [5] 111:9 225:18  360:19 410:4 458:11  <b>dates</b> [2] 232:1 233:5  <b>David</b> [1] 433:16  <b>Dawe</b> [7] 213:4,25 214:4  214:22 341:14 342:13  343:7  <b>days</b> [9] 57:19 58:14  67:25 137:19 218:4  295:16 332:13 439:15  457:9  <b>DCIS</b> [12] 14:5,12,18  74:23 75:16 129:14 131:9  131:10,12,18,20 268:24  <b>de-identified</b> [2] 199:18  199:18  <b>de-minimize</b> [1] 430:22  <b>deadline</b> [2] 187:21,23  <b>deal</b> [13] 11:5 13:4 48:1  56:19 59:16 280:5 282:8  282:21 285:5,6 335:20</p>	<p><b>December</b> [18] 84:6 96:8  96:9 137:9 143:22 153:14  154:21 157:15 168:21  185:19 215:25 216:3  217:7,9 237:20 238:2  262:14 410:4  <b>decided</b> [14] 59:25 74:24  77:23 78:17,20 103:6  161:11 177:17 250:7  262:19 383:7 408:19,21  433:5  <b>deciding</b> [2] 81:21 456:1  <b>decision</b> [34] 83:8 154:3  161:16 162:7 164:4 165:2  169:12,22,24 170:1,4  176:19 179:12 182:10  199:11 202:24 250:6,11  254:19 255:25 260:3  267:4 290:19 337:1,6,15  366:21 383:2 396:12  398:10 415:9 442:15  443:22 444:6  <b>decisions</b> [10] 91:12  151:6 186:21 266:22  336:21 337:23 338:13  366:18,19 451:14  <b>declined</b> [1] 79:13  <b>declining</b> [1] 79:16  <b>decrease</b> [1] 422:8  <b>default</b> [2] 283:18,22  <b>defence</b> [4] 166:10,19  167:24 212:20  <b>Defendant</b> [1] 43:25  <b>deficient</b> [1] 206:6  <b>define</b> [1] 389:11  <b>defined</b> [1] 229:4  <b>definitely</b> [20] 39:5 65:3  275:6 283:16 299:18  302:15 304:23 311:7  314:20 327:8 354:14  359:6 372:5 373:23 380:3</p>	<p><b>Denic's</b> [1] 381:9  <b>denied</b> [1] 201:8  <b>denominator</b> [1] 141:2  <b>denying</b> [1] 73:13  <b>department</b> [34] 6:4  28:25 37:25 39:21,23  71:18,20 93:11 122:16  123:3,15 126:15 235:5  252:8 285:13 286:11  288:19 289:18,23 290:11  292:21 293:1 295:18  301:19 303:2 308:10,14  359:18 376:11 385:6  402:6 412:9 416:24 436:7  <b>departments</b> [1] 299:12  <b>depend</b> [2] 301:21  384:16  <b>depended</b> [1] 60:13  <b>depending</b> [5] 47:7  291:13 385:2 411:2 424:2  <b>deputy</b> [2] 393:25 394:5  <b>describe</b> [6] 17:21 26:10  27:22 28:2 258:23 402:18  443:22 444:6  <b>described</b> [10] 23:10  278:13 285:14 342:9  347:13 397:7 398:12  453:5 455:16,17  <b>description</b> [12] 18:10  231:21,25 331:8 357:9  374:25 379:3,19 398:9  425:18 450:20 455:18  <b>designed</b> [1] 290:23  <b>desirability</b> [1] 125:9  <b>despite</b> [1] 380:25  <b>detail</b> [22] 19:7 29:1  106:11 134:8,15,16,20  134:21,22 189:16 200:14  204:1 307:1 325:3 331:16  331:21 332:21,23 333:21  339:22 385:2 433:24  <b>detailed</b> [3] 135:10  342:25 374:8  <b>details</b> [10] 19:16 23:16</p>	<p>42:18 51:1 62:4 64:19  213:20 220:23 221:10  304:16  <b>detect</b> [1] 431:1  <b>detected</b> [1] 408:24  <b>determine</b> [13] 32:13  118:8,13 122:11 152:18  179:3 182:1,25 193:3  329:18 336:12 390:9  400:22  <b>determined</b> [7] 31:3  33:17 153:23,25 162:12  178:24 432:4  <b>determining</b> [2] 151:5  425:18  <b>deterred</b> [1] 340:17  <b>develop</b> [2] 282:20 298:8  <b>developed</b> [6] 29:13 55:8  56:8 213:13 282:16 400:6  <b>developing</b> [3] 50:23  123:24 338:19  <b>development</b> [1] 123:25  <b>developments</b> [1]  231:14  <b>diagnosed</b> [8] 30:21 31:5  33:11 62:12 74:14 365:22  408:12,13  <b>diagnosis</b> [4] 75:17  131:11 262:16 264:15  <b>Dianne</b> [3] 267:12,13  453:11  <b>died</b> [4] 46:17,21 62:1  333:10  <b>differ</b> [1] 47:7  <b>difference</b> [2] 157:3  250:13  <b>different</b> [32] 30:19,19  43:12 45:4 47:23 51:2  67:20 153:22 216:15  217:18 253:19 255:19  282:25 293:18 297:5  332:8,9 334:11,17,20  348:3 359:3 374:9 376:1  376:3 385:9 411:2 424:4  429:6,7,8 432:2  <b>differentiate</b> [3] 28:1  84:6 315:20  <b>differentiating</b> [2] 84:8  303:15  <b>differentiation</b> [1]  27:24  <b>differently</b> [3] 218:5  257:1 297:6  <b>difficult</b> [8] 91:10,12  93:14,15 120:25 213:15  214:10 325:11  <b>difficulties</b> [3] 190:22  192:5 223:2  <b>difficulty</b> [3] 103:15  106:6,7  <b>dilemma</b> [1] 387:21  <b>direct</b> [9] 41:13 50:8  72:25 117:1 286:15,16  341:8 342:14,16  <b>directed</b> [2] 13:18  440:20</p>	<p><b>directing</b> [2] 18:2 51:7  <b>direction</b> [16] 81:7 108:7  135:24 200:6 214:8,14  216:23 344:23 346:7,16  350:1 355:19 393:9 438:5  438:10 444:12  <b>directly</b> [9] 14:16 39:10  39:14,22 109:21 113:4  210:25 355:22 424:7  <b>director</b> [1] 60:4  <b>directory</b> [1] 18:3  <b>disagreement</b> [2] 291:2  311:20  <b>disappointed</b> [1] 53:18  <b>disappointment</b> [1]  342:6  <b>discharge</b> [1] 91:4  <b>discharged</b> [2] 90:18,22  <b>disciplinary</b> [1] 10:4  <b>disclaimer</b> [1] 272:15  <b>disclose</b> [16] 74:18 75:10  76:6 81:6 168:22 212:13  250:18 278:22 392:24,24  393:2,3 438:2,3 448:20  448:24  <b>disclosed</b> [10] 77:1 92:10  180:14 182:11 183:8  187:10 333:8 393:3,5  448:16  <b>disclosing</b> [4] 181:2  407:5 443:2,4  <b>disclosure</b> [43] 76:9  207:11,20 208:3,12  278:19 279:11,24 331:13  333:25 334:6 392:23  394:13,14,24 395:21  396:4,9 400:1,11,12,19  401:11 402:1,7,7,22  403:1,5 404:1 423:17  433:14 437:24 438:7,8  439:20 442:2 444:11,15  444:23 446:13,23 447:9  <b>disclosures</b> [1] 212:18  <b>disconnect</b> [1] 209:1  <b>discover</b> [4] 69:22  302:10 330:7,15  <b>discovered</b> [11] 32:25  39:8 41:6 74:25 76:1  255:22 261:13 288:12  345:17 420:24 448:25  <b>discovery</b> [2] 41:19  317:11  <b>discrepancy</b> [1] 353:17  <b>discuss</b> [17] 16:13 73:19  75:22 83:4 93:21 94:15  104:24 116:5,6 146:6  169:6 183:7 184:5 272:13  385:7 388:24 440:8  <b>discussed</b> [30] 16:2 17:2  25:22 29:1 33:23 34:2  51:12 73:2,22 75:16  103:5 116:9 136:25  139:12 154:22 163:1  180:13,15 182:8,21  201:16 207:22 269:7  349:20,21 384:5 395:19  433:25 441:6 452:13</p>

<p><b>discussing</b> [11] 33:5 51:16 53:23,25 171:12 207:2,19 244:23 297:18 325:8 440:19</p> <p><b>discussion</b> [90] 13:7 15:22 18:20 19:3,11 20:18,20 22:3 25:11,21 36:17 41:15 43:15 44:21 45:18 46:6 48:7 50:3,10 50:13,16 51:10 52:24 53:3 54:8 56:19 62:3 63:11 74:18 75:9,13 76:13,17 77:23 85:1,11 89:14 95:25 96:3 105:3 105:8 114:20,24 116:2,6 116:12 121:21 129:7 138:3,7 139:19 156:14 160:1,8 178:2 180:22 182:6,15 183:22,23 187:2 199:14,15,20 203:9 204:18,23 240:16 242:12 249:24 258:10 268:23,24 272:9 273:16,23 275:16 276:17 278:3 289:4 340:9 343:19 351:4 372:13 399:9 411:9 439:2 444:5 446:23 451:2</p> <p><b>discussions</b> [14] 72:25 93:9 152:15 155:6,19 157:13 165:1 180:19 181:3,9 186:22 233:9 249:3 256:4</p> <p><b>disease</b> [18] 14:3 24:10 24:11 25:4 29:12,13,17 29:21,22 30:9 31:20 33:19 34:3,8 37:7 45:9 133:3 148:2</p> <p><b>disheartened</b> [1] 91:19</p> <p><b>disregarded</b> [1] 444:8</p> <p><b>distinction</b> [4] 30:8 419:11 421:14 427:3</p> <p><b>distinctly</b> [1] 112:11</p> <p><b>distinguish</b> [1] 394:9</p> <p><b>distinguishing</b> [1] 23:22</p> <p><b>distressed</b> [1] 92:20</p> <p><b>disturbing</b> [1] 215:4</p> <p><b>division</b> [2] 1:15 122:4</p> <p><b>divulging</b> [1] 366:25</p> <p><b>doctor</b> [4] 69:19 90:20 90:22 268:1</p> <p><b>doctor/doctors</b> [1] 268:1</p> <p><b>doctors</b> [4] 1:9 79:5 115:7 239:19</p> <p><b>document</b> [38] 11:22 20:8 96:23 97:14,16 102:17 105:5,11 106:13 106:15 113:15,18 118:9 132:3 145:14 224:6,7 230:25 258:6 260:20 286:3,21 393:17 399:18 403:19 406:18 412:1,2 416:22 419:2,5,6,17 421:6 425:24 428:4 431:9 432:20</p> <p><b>documentation</b> [38] 103:12 105:10 117:16,17 118:20,22,24 119:4,22</p>	<p>121:10,23 124:9,24 125:15,17 126:2,8,10 172:14,19,24,25 173:1 226:25 227:1,3,4 228:3 228:8 229:7 230:3,4,7 230:21 323:3,10,15 324:5</p> <p><b>documented</b> [9] 83:5 85:3 118:21 195:6 228:9 230:5,9 297:12 305:13</p> <p><b>documenting</b> [3] 125:21 311:4 338:20</p> <p><b>documents</b> [8] 125:9 224:19,20 320:23 343:17 364:24 392:11 425:10</p> <p><b>doesn't</b> [9] 26:9 120:4 192:24 213:20 219:13 220:22 337:1 379:19 419:8</p> <p><b>Don</b> [1] 97:24</p> <p><b>done</b> [69] 6:23 14:25 24:12 45:11 48:1 49:24 50:5 52:12 65:13 67:16 98:17,17 102:8,9 122:12 125:5 132:10 144:2 155:4 155:17 158:7 163:11 167:9 173:7 190:15 211:11,15 250:1 262:15 262:20 264:3 268:18 269:2 283:1 288:10,13 299:1 306:19 307:23 308:13 315:8,18,19 326:13,21 327:5,9,19 329:3,11,12,19 330:25 331:17 335:14 336:6 338:12 339:1 380:15 382:19,21 386:25 399:16 432:14 435:20,22,23 452:6 456:4</p> <p><b>door</b> [1] 89:7</p> <p><b>double</b> [6] 288:8,9,16 302:3 327:17 330:2</p> <p><b>doubt</b> [7] 21:9 276:4 281:2,11 322:22 325:3 391:25</p> <p><b>doubts</b> [1] 371:6</p> <p><b>Doucette</b> [1] 18:19</p> <p><b>down</b> [44] 6:18 15:3 64:21 81:24 82:11 84:17 87:21 109:20 113:19,19 119:5 139:23 156:3 182:24 201:12 212:6 219:15 262:14 283:6 286:19 297:25 304:15,16 313:12 314:4 323:25 349:10,11 354:1,22 355:23 362:21,24 363:16 371:14 378:1 379:11 381:19 385:20 400:25 406:19 410:3 418:5 426:4</p> <p><b>DP</b> [1] 244:2</p> <p><b>Dr</b> [197] 8:16,16,21,22 12:11,11 13:6 50:9,21 50:22 56:16 59:19 64:9 64:9 69:5,7 74:10,10 88:20 91:17,20 92:7,14 93:19 95:5,6 96:1,18 97:6,8 98:13 99:9,11 102:6 103:7,8 104:25 105:1 108:6,16,18 114:9</p>	<p>115:1 116:4 122:2,3 123:23 127:19 128:5 129:19 130:8 135:3,23 145:20 146:18 155:2 158:9,16 159:1,8,13 160:8,16 161:16 165:6,9 165:9 173:22 179:1 184:17,17,18,19,19 188:3 188:22 190:4,24 191:3 192:5 193:12,13 194:1 194:17 195:9,14,22 196:11 200:23,25 202:19 202:21 207:3 212:1 226:17 230:13,23 232:6 232:20 243:25 244:8,15 258:7,8 259:8,14 262:18 263:11,16 264:8 268:18 268:21 269:3,6,14 271:2 276:23 286:7 291:25 315:5,5,7,10 318:15,23 322:7 341:19 342:10 346:1,6,8 347:4,5,11,11 347:25 348:9,10,23,25 349:4,16,19 350:10,17 350:25 351:8,25 352:8,9 352:17 354:1 355:14,18 355:19 358:11,14,17 359:7 360:20,21 363:11 370:16 376:23 380:24 381:9 398:12 399:8 401:3 408:16,16,19 409:2,15 409:17 415:21 419:14,15 419:24 420:3,8 422:2 425:12,18 426:20 437:22 438:25 439:1 442:14 443:12,19 444:4,8 445:13 450:7 453:18 456:10</p> <p><b>draft</b> [15] 8:12,16,21 13:5 20:2,3 23:6 54:21 68:24 131:13 132:7 186:6 198:14 317:6 403:8</p> <p><b>drafted</b> [7] 51:9 54:4 132:16 255:9 319:8 401:3 402:23</p> <p><b>drafting</b> [4] 7:16 402:6 402:10,11</p> <p><b>dramatic</b> [1] 385:15</p> <p><b>dramatically</b> [2] 43:12 439:14</p> <p><b>draw</b> [1] 406:24</p> <p><b>drawn</b> [2] 91:11 230:23</p> <p><b>drew</b> [1] 341:11</p> <p><b>dropped</b> [1] 307:16</p> <p><b>Drs</b> [2] 195:5 200:23</p> <p><b>drug</b> [2] 48:15 300:12</p> <p><b>drugs</b> [2] 304:6,8</p> <p><b>dual</b> [1] 290:13</p> <p><b>ductal</b> [1] 262:16</p> <p><b>due</b> [11] 317:10,16 326:13 326:20 329:2 331:16 335:13 336:6 338:4 375:12,23</p> <p><b>during</b> [17] 9:20 31:3 32:8 33:18 114:24 115:21 159:10 160:8 212:11 228:4 236:5 245:22 273:16 349:20 353:14 400:20 415:16</p> <p><b>duty</b> [4] 200:11 422:21</p>	<p>423:12,16</p> <p><b>DVT</b> [1] 48:16</p> <p><b>dynamic</b> [1] 156:1</p> <hr/> <p style="text-align: center;"><b>-E-</b></p> <hr/> <p><b>e</b> [8] 112:17 193:15 221:4 222:6 260:7 329:11,19 362:16</p> <p><b>e-mail</b> [64] 4:12 5:4 6:25 13:12 20:9 23:20 28:13 61:18 68:12,14 70:9 74:8 79:21 82:21 93:18 94:5 95:2 97:22 127:18 129:17 129:22 136:6,8 145:13 145:18 158:2 178:5 187:17 188:3 194:15 200:22 205:14 206:10 209:24 211:25 212:21 214:2 215:23 220:19 222:12 223:16,18 224:3 224:24 231:13 234:2 237:18,20 242:6 251:25 252:16 254:5 259:24 267:12 362:12,21 363:1 412:13 414:5 417:1 437:21 438:14 442:11 453:10</p> <p><b>e-mailing</b> [2] 109:21 197:19</p> <p><b>e-mails</b> [3] 4:14 215:17 356:24</p> <p><b>early</b> [9] 57:19 58:14 63:10 275:9 308:20 315:4 320:22 358:16 372:14</p> <p><b>ease</b> [1] 305:17</p> <p><b>easier</b> [1] 335:20</p> <p><b>easily</b> [5] 85:11 190:12 246:8 306:18,21</p> <p><b>Eastern</b> [65] 1:10 15:17 19:16,19 24:6 37:24 41:20 42:7 44:1,14,15 44:21 45:6 47:15,16 49:9 52:23 55:5 70:11,15 79:12 82:17 126:5 170:2 198:7 202:24 212:12 220:10 222:15 234:19 237:21,25 238:3 241:3 242:23 247:10 272:24 276:1 278:4 279:6,14,22 281:3,12 310:12 317:11 317:21 326:11 330:24 342:15 357:23 394:23 397:3,21 402:25 406:25 415:20 416:3,15 423:23 435:16,23 438:6,9 454:10</p> <p><b>Eastern's</b> [1] 18:2</p> <p><b>educating</b> [2] 337:10 432:15</p> <p><b>education</b> [6] 305:8 336:19 338:5 394:8 432:15 433:2</p> <p><b>effect</b> [7] 49:3 211:1 279:24 317:24 403:22 430:9 439:16</p> <p><b>effectively</b> [2] 136:18 275:21</p> <p><b>effects</b> [2] 297:20 338:16</p> <p><b>efficiency</b> [1] 389:22</p>	<p><b>efficiently</b> [4] 283:13,21 283:21 285:7</p> <p><b>effort</b> [5] 210:7 237:11 338:19 339:6,12</p> <p><b>efforts</b> [3] 237:10 258:1 354:10</p> <p><b>eight</b> [6] 186:7 262:14 349:11 379:17 385:20 453:7</p> <p><b>either</b> [21] 17:9 19:7,18 70:23 124:4 135:16 159:16 174:14 243:13 254:11 326:19 343:6 355:21 365:20 370:15 376:23 380:10,23 405:19 421:19 452:2</p> <p><b>Ejeckam</b> [2] 232:6 233:15</p> <p><b>elaborate</b> [1] 300:1</p> <p><b>electronic</b> [6] 305:15 306:4,12,22 308:13,15</p> <p><b>elicit</b> [3] 342:19,25 343:7</p> <p><b>eliminate</b> [1] 194:25</p> <p><b>Elliott</b> [22] 4:13,21 7:18 8:14 38:25 40:16 61:20 68:2 72:1,10,18 74:11 97:23 101:5 107:24 129:23 189:21 203:13 205:4 240:7 244:10,25</p> <p><b>Elms</b> [5] 97:24 103:7 115:1,8 122:3</p> <p><b>Elms'</b> [1] 108:6</p> <p><b>eloquently</b> [1] 456:11</p> <p><b>elsewhere</b> [2] 426:1 435:5</p> <p><b>embarrassing</b> [1] 137:14</p> <p><b>embedded</b> [1] 414:4</p> <p><b>embroiled</b> [1] 397:4</p> <p><b>emergency</b> [2] 196:13 408:25</p> <p><b>emphasized</b> [1] 120:10</p> <p><b>employee</b> [1] 107:19</p> <p><b>enable</b> [1] 329:18</p> <p><b>enables</b> [1] 283:20</p> <p><b>enabling</b> [1] 283:12</p> <p><b>encompass</b> [1] 402:17</p> <p><b>encounter</b> [1] 284:3</p> <p><b>encouraged</b> [2] 295:18 437:8</p> <p><b>end</b> [15] 7:9 9:9 11:9,19 15:15 37:22 70:17 155:4 186:1 276:12 289:12 293:21 305:7 393:21 399:11</p> <p><b>ended</b> [2] 33:3 113:11</p> <p><b>endometrial</b> [1] 48:19</p> <p><b>ends</b> [2] 37:19 132:6</p> <p><b>engaged</b> [1] 49:9</p> <p><b>England</b> [1] 293:18</p> <p><b>ensued</b> [1] 116:2</p> <p><b>ensure</b> [7] 119:19 121:18 122:18 127:6 158:4 195:6 195:8</p>
--	---	---	---	---

<p><b>ensuring</b> [1] 120:11  <b>enter</b> [4] 227:5 294:4,14 295:9  <b>entered</b> [5] 67:2 263:25 286:9 294:21 295:14  <b>entire</b> [5] 91:10 107:22 121:23 188:14,20  <b>environment</b> [1] 424:16  <b>environments</b> [1] 329:24  <b>equal</b> [1] 125:18  <b>equally</b> [1] 333:4  <b>equipment</b> [8] 311:24 312:4 319:11 322:5 325:12 436:20,25 437:4  <b>equivocal</b> [1] 408:16  <b>ER</b> [49] 41:7 62:16 68:5 235:7 236:10 246:4,4 262:13,21 264:7,17 276:1 276:2 348:16,17 359:12 360:2,3,10 364:15,16 365:24 366:3 373:12 376:25 377:25 378:1,3 378:10,19,21 379:13 380:8,11,20 381:23 383:15 408:15 409:4 416:6,13,14 420:25 421:3 421:10,19,24 422:3 425:16  <b>ER/PR</b> [56] 13:22 15:16 20:17 23:11 24:2,8 30:10 30:22 33:12 45:8 49:1 62:17 68:4 76:21 83:3 84:13 91:10,21 95:7 98:5 101:19,21 116:22 127:19 188:10 199:17 201:3,5 203:16 205:21 207:18 208:18 209:3,10 210:3 211:14 212:2 239:10 262:12,20 264:14 268:18 280:13,16 298:18 309:12 309:23 318:4 334:7 339:21 341:21 342:20 350:16 380:7 392:21 400:21  <b>erroneous</b> [5] 19:9 49:7 51:8 247:24 248:12  <b>error</b> [30] 57:13 136:7,9 137:10 138:1,12,22 139:10 140:16 141:19 142:15 144:7 146:25 147:16,18 149:1,3 150:4 152:11,14,19 153:6,24 153:25 157:16 158:6 162:19,25 170:18 171:15  <b>errors</b> [7] 327:21 341:7 341:13 394:9,16,24 433:13  <b>ERs</b> [1] 370:24  <b>especially</b> [3] 89:12 329:23 347:3  <b>essence</b> [1] 441:12  <b>essentially</b> [2] 317:23 322:11  <b>establish</b> [1] 116:18  <b>established</b> [5] 42:7 93:11 168:3 316:14 432:9  <b>establishing</b> [1] 316:4</p>	<p><b>estimate</b> [2] 228:12,15  <b>estimating</b> [1] 388:18  <b>estrogen</b> [3] 16:19 70:12 365:24  <b>et</b> [4] 1:9 195:3 208:2 317:13  <b>etcetera</b> [1] 22:19  <b>ethical</b> [3] 208:6 258:10 259:6  <b>ethicist</b> [1] 206:4  <b>ethics</b> [13] 15:14 205:22 206:2 207:6 208:4,8 341:1 395:18,20 396:3 397:13,22 398:4  <b>evening</b> [1] 158:23  <b>event</b> [17] 67:10 74:2 77:16 85:15 90:11 107:9 136:12 270:21 280:17 282:9 284:24 300:10 357:3 382:8 390:3,10,14  <b>events</b> [15] 214:14 278:12 278:19 279:2,5,12,24,25 389:8,12,16 399:22 400:3 404:2,6  <b>eventually</b> [1] 202:14  <b>everybody</b> [16] 9:14 73:13 93:14 144:11 156:15 179:13 223:6,14 240:22 243:19,22 255:22 306:6 313:18,19 332:4  <b>everybody's</b> [1] 125:19  <b>evidence</b> [42] 26:22 85:4 116:2 129:8 195:6 271:14 272:5 284:23 285:16 286:8,12 287:4 288:16 293:14 295:16 298:17 299:11 300:18 309:10 317:8,14 332:12 341:14 341:16 345:25 346:9 348:24 355:14 358:16,18 358:21 368:25 371:7 381:1,9,25 382:16 400:1 401:21 421:18 446:9 455:20  <b>evident</b> [3] 266:7 450:11 451:11  <b>evolved</b> [1] 450:22  <b>exact</b> [2] 22:13 286:17  <b>exactly</b> [26] 47:20 52:5 55:18 56:5 78:15 87:18 123:22 139:1 151:9 152:24 154:5 183:5 254:17,22 274:17 285:9 296:14 298:6 310:7 313:3 313:25 376:7 406:12 420:13 423:10 427:22  <b>exaggerating</b> [1] 101:8  <b>Examination</b> [12] 2:3,4 2:5,6,7,8 4:3 271:23 277:22 388:22 424:25 455:5  <b>examined</b> [1] 61:3  <b>example</b> [23] 16:11 72:1 134:11 226:20 230:13 232:22 249:5 259:1 266:21 287:25 288:7 304:5 311:19,20 338:20</p>	<p>348:16 376:12 380:19,21 436:19,21 437:12 448:16  <b>examples</b> [3] 297:1 300:9 371:2  <b>excellent</b> [2] 402:14 405:17  <b>except</b> [5] 130:4 193:20 223:16,18 242:25  <b>exception</b> [3] 18:10 46:11 47:24  <b>exceptions</b> [2] 207:20 208:9  <b>exchange</b> [7] 13:12 20:9 28:13 61:19 74:8 127:18 234:2  <b>exclude</b> [1] 363:22  <b>excluded</b> [2] 360:6 381:23  <b>excluding</b> [1] 363:16  <b>exclusive</b> [1] 37:2  <b>Excuse</b> [1] 180:25  <b>executive</b> [15] 95:8 96:1 96:7 97:11 98:14 106:24 107:5,11 108:11,18 112:4 115:6 116:21 117:14 393:19  <b>exercise</b> [5] 283:1 296:16 383:8 395:25 401:21  <b>exhibit</b> [16] 269:25 286:6 286:17 294:13,18 295:5 315:2 317:4 364:21 365:22 370:13 379:1 380:5 418:2 452:20 454:8  <b>exhibits</b> [6] 3:1,2 294:4 295:14 408:6,6  <b>exist</b> [3] 320:24 449:6,8  <b>existence</b> [4] 11:4 230:20 231:19 232:23  <b>exit</b> [1] 272:8  <b>expect</b> [7] 90:25 125:24 214:8 216:14 222:10,24 322:10  <b>expectations</b> [1] 207:24  <b>expected</b> [11] 82:13 86:24 87:7,15 125:24 204:16 210:8 310:19 320:24 323:4 429:17  <b>expeditiously</b> [1] 201:18  <b>experience</b> [12] 49:2 99:11 116:3 125:13 306:2 322:25 323:9 328:5,13 333:1 336:19 389:19  <b>experiences</b> [1] 334:1  <b>explain</b> [13] 16:19 30:7 137:11,16 192:11 237:19 243:21 254:18,23 321:21 348:21 397:19 404:4  <b>explained</b> [3] 22:14 82:11 147:23  <b>explaining</b> [2] 146:19 212:22  <b>explanation</b> [7] 81:17 135:10 136:9,11 137:9 340:16 376:13  <b>express</b> [1] 238:6</p>	<p><b>expressed</b> [6] 60:25 98:20 170:17 342:6 356:13 443:17  <b>expressors</b> [4] 154:8,9 154:10,11  <b>extend</b> [1] 116:21  <b>extensive</b> [2] 288:8 381:11  <b>extent</b> [1] 16:9  <b>external</b> [16] 17:3,4 49:9 51:18 53:13 98:18 102:9 193:18 206:21 229:1,1 314:15 315:17 316:5 342:11 445:13  <b>extra</b> [2] 17:20 18:6  <b>extreme</b> [1] 338:17</p> <hr/> <p style="text-align: center;"><b>-F-</b></p> <hr/> <p><b>face</b> [2] 101:11 275:21  <b>faced</b> [1] 208:22  <b>faces</b> [1] 388:3  <b>facilitated</b> [1] 366:19  <b>facing</b> [1] 432:7  <b>fact</b> [63] 23:17 32:15 36:12 45:18 50:14 58:14 60:24 62:24 64:21 81:9 83:10 89:11 90:5 100:7 104:10 106:17 111:9 120:9 127:6 132:19 140:10 141:7 142:24,25 150:11 195:1 210:24 211:6 214:4 215:6 216:15 222:12 223:4 230:13 236:20 240:1 242:19 243:18 259:14 262:11 270:6 285:5 293:17 320:10 322:5 334:22 342:16 353:11 354:11,18 368:7 371:21,23 372:2 374:18 413:3 416:2 420:24 423:7 445:2,17 448:19 449:6  <b>factor</b> [6] 74:22 77:6 303:1 321:24 335:3 342:5  <b>factors</b> [13] 67:20 136:21 141:24 162:18 178:8,17 184:3 301:18 307:5,23 327:6 328:9 344:1  <b>facts</b> [5] 242:18 438:3 448:14,15,15  <b>factual</b> [1] 445:22  <b>failure</b> [3] 297:20 338:15 432:16  <b>faint</b> [1] 62:13  <b>fair</b> [7] 276:6 281:23 390:4 433:24 438:20 446:16 456:24  <b>fairly</b> [11] 18:16 76:10 130:3 201:25 223:23 237:19 246:14 257:15 287:5 366:12 428:17  <b>faithful</b> [1] 455:11  <b>fall</b> [7] 9:11 62:7,24,25 196:4 301:5 345:23  <b>falling</b> [2] 84:22 87:21  <b>falls</b> [1] 83:6</p>	<p><b>false</b> [7] 83:5 84:23 85:3 86:16 144:18 357:20 375:13  <b>familiar</b> [7] 285:23 296:1 341:15,21 362:16 370:21 415:22  <b>familiarity</b> [1] 422:20  <b>familiarize</b> [2] 286:20 371:4  <b>families</b> [12] 22:2,17 46:17,21 56:9 57:8,18 58:2 59:8 250:4 252:2,9  <b>family</b> [26] 15:16 56:11 59:14,19 79:6,8 80:9,12 80:18,23 81:1,1,13 87:3 88:2,6,16,24 89:8,14 90:4,20,22 196:13 340:16 433:14  <b>fan</b> [3] 213:7 215:13 218:17  <b>far</b> [10] 36:22 128:8 137:4 148:5 181:19 251:8 346:19 370:11 403:17 442:5  <b>farther</b> [2] 144:9 426:4  <b>fashion</b> [1] 286:16  <b>father</b> [1] 333:9  <b>fault</b> [1] 337:24  <b>favour</b> [1] 408:20  <b>fear</b> [1] 396:17  <b>features</b> [2] 329:6,18  <b>February</b> [13] 109:11 109:14 111:15 126:14 185:17 186:2 188:10 192:22 198:7 199:10 204:10 225:25 366:5  <b>feedback</b> [15] 9:15 12:10 12:12 89:13 90:1 107:25 137:7 189:7 286:15 289:14,17 305:24 321:2 396:12,24  <b>feeling</b> [3] 16:17 246:18 387:14  <b>feels</b> [4] 194:21 212:4,25 258:8  <b>Felix</b> [7] 195:5 196:11 268:21 269:3,6,14 271:2  <b>fell</b> [2] 65:6 67:15  <b>felt</b> [19] 9:2 21:14 25:3 40:6,15,20 76:3 98:15 98:16 114:21 129:12 138:15 208:2 216:2 236:3 243:16 250:18 324:2 348:19  <b>Femara</b> [2] 74:17 75:6  <b>fertility</b> [1] 48:22  <b>few</b> [17] 13:18 60:18,21 67:25 145:7 206:1 218:7 236:5 241:18 272:3 278:1 295:16 323:16 339:18 346:21 377:23 457:9  <b>field</b> [2] 112:17 326:7  <b>fifteen</b> [2] 134:1 224:23  <b>figure</b> [6] 114:20 139:9 192:17 255:17 283:3 411:20</p>
--	---	---	---	--

<p><b>figures</b> [1] 140:4  <b>figuring</b> [3] 67:14  142:14 149:18  <b>file</b> [4] 299:22 344:15  356:19 406:16  <b>filed</b> [8] 18:18 43:24  185:19,24 187:15 199:10  204:9 420:4  <b>files</b> [1] 364:25  <b>fill</b> [5] 289:4,6 296:6  297:3 305:4  <b>filled</b> [3] 8:5 263:4  296:23  <b>final</b> [18] 20:3,11,13 23:6  37:18 38:9 54:2 78:8,11  78:13 132:6 172:8 257:17  333:14,14 381:18 452:19  453:5  <b>finally</b> [3] 331:3 406:20  457:11  <b>finding</b> [4] 286:24  332:18,21 339:20  <b>findings</b> [2] 53:9 115:23  <b>fine</b> [5] 61:17 121:10  153:3,4 382:8  <b>finish</b> [2] 184:24 220:19  <b>finished</b> [4] 53:6,7  191:12 450:12  <b>fires</b> [3] 213:8 215:13  218:17  <b>firm</b> [1] 245:25  <b>first</b> [63] 4:14,18 5:7,10  5:11,15 8:3 31:16 36:5  37:22 75:19 80:11 82:9  86:20 91:19 93:17 98:6  104:22 116:17 125:23  134:7 137:7 160:13  173:23 181:25 184:13  188:23 194:15 202:11  205:10 213:22 234:1  239:12 251:1 255:3  268:24 290:22 301:22  302:14 309:24 317:9  341:1,17 350:9 360:18  366:10 374:1,18 380:11  388:25 394:9 403:14  417:3,5 423:17 425:11  432:25 433:17 438:4  440:13 442:8 446:8  456:16  <b>fist</b> [1] 398:13  <b>fit</b> [7] 36:19 120:4 287:10  379:18,19 430:14 431:3  <b>fits</b> [4] 287:20 379:2  413:15 431:7  <b>five</b> [12] 83:6,17 84:20  85:16 91:2 95:5 224:4  365:25 383:15 409:6  451:21,23  <b>fix</b> [2] 289:12 290:23  <b>fixation</b> [2] 118:2 273:1  <b>flagging</b> [1] 275:9  <b>floor</b> [1] 307:17  <b>flow</b> [1] 283:9  <b>focus</b> [10] 11:1 162:8  243:15 316:25 351:25</p>	<p>381:13 400:11 424:15,17  430:8  <b>focused</b> [3] 282:17 389:7  390:2  <b>fodder</b> [4] 213:7 215:13  215:14 218:12  <b>Fog</b> [1] 213:5  <b>follow</b> [14] 28:17 30:6  78:2,21 193:13 195:7  249:21 281:3,12 392:1  392:10 397:12 405:1  430:25  <b>followed</b> [8] 69:16 82:1  90:20 158:9 261:23 271:2  322:17 349:1  <b>following</b> [13] 42:18  66:9 81:22 90:23 115:21  137:3 267:22,23 299:20  323:21 341:18 437:22  452:7  <b>Ford</b> [1] 97:24  <b>foregoing</b> [1] 458:2  <b>foreign</b> [1] 423:3  <b>forever</b> [1] 124:22  <b>forget</b> [1] 251:8  <b>forgetting</b> [1] 162:24  <b>forgotten</b> [1] 428:13  <b>form</b> [6] 124:7 321:2  405:11 406:1 410:16  440:12  <b>formal</b> [2] 203:15 313:16  <b>formally</b> [1] 296:21  <b>format</b> [3] 411:3 429:5  450:25  <b>formatted</b> [1] 9:14  <b>forms</b> [1] 292:13  <b>formulating</b> [1] 398:24  <b>forth</b> [3] 5:3 7:17 51:14  <b>forthcoming</b> [1] 403:2  <b>forward</b> [15] 18:1,7  25:15 53:17,22 83:11  135:7 149:17 185:6,15  222:13 223:4 261:12  275:3 419:17  <b>forwarded</b> [4] 195:2  219:22 237:16 425:25  <b>forwarding</b> [4] 69:18  69:19 197:25 224:15  <b>forwards</b> [1] 234:24  <b>found</b> [15] 89:11 100:20  124:14,16 125:22 185:23  185:25 214:9 226:18  230:14 247:8 303:7  421:24 433:1 450:5  <b>four</b> [16] 83:21,23 84:15  85:16 150:21 244:6  357:18 362:12 368:20  369:21 378:24 381:1,10  414:18,24 418:5  <b>fourth</b> [2] 394:12 426:4  <b>frame</b> [2] 354:17 409:6  <b>Frankly</b> [1] 457:11  <b>free</b> [5] 404:3 448:3,8,19  448:24  <b>frequent</b> [1] 252:8</p>	<p><b>frequently</b> [1] 308:17  <b>Friday</b> [9] 97:25 103:5  103:16 104:21 205:16  247:9,13 415:3,15  <b>front</b> [2] 289:12 421:7  <b>frontline</b> [2] 304:25  308:6  <b>frustrated</b> [2] 398:23  399:9  <b>frustration</b> [1] 87:20  <b>full</b> [12] 148:17 200:13  364:12 394:13,14,23  396:4 437:1 446:13,22  447:9 450:13  <b>fully</b> [3] 26:9 136:16  196:14  <b>function</b> [1] 429:18  <b>fundamental</b> [1] 326:25  <b>fundamentally</b> [1]  403:3  <b>fundamentals</b> [1] 16:20  <b>future</b> [4] 49:25 119:22  120:23 245:20  <b>FYI</b> [1] 69:4</p> <hr/> <p style="text-align: center;"><b>-G-</b></p> <p><b>gamut</b> [1] 338:25  <b>Gander</b> [1] 379:11  <b>Ganguly</b> [6] 91:17,20  92:8,14 408:16,18  <b>gap</b> [1] 92:13  <b>gaps</b> [1] 387:1  <b>Gary</b> [3] 18:1 21:23 38:1  <b>gather</b> [3] 392:14 407:15  442:4  <b>general</b> [12] 63:11 89:1  136:14 181:20,22 213:19  220:22 287:5 326:18  331:21 342:8 358:2  <b>generally</b> [11] 94:15  278:8 280:5 318:24 344:3  352:2 390:25 434:1 443:6  445:24 447:3  <b>generated</b> [1] 201:18  <b>generic</b> [5] 63:14,25  64:14,18,20  <b>genetic</b> [1] 323:24  <b>gentleman</b> [1] 68:4  <b>George</b> [2] 212:9 237:17  <b>gist</b> [2] 141:15 331:22  <b>given</b> [41] 24:16 48:10  54:5 81:7 96:6 122:9,10  127:3 135:11 141:7 143:6  173:12 177:19 181:6,17  217:14 225:10 239:11  253:22 255:13 270:7  271:3 310:21 328:2  342:12 346:7 351:10  355:19 356:12 358:16  366:7 376:9 378:25  379:16 380:24 381:19  385:1 406:2 415:9 438:15  441:17  <b>giving</b> [25] 40:20 96:1  110:11 119:24 129:4</p>	<p>134:9 140:3 143:7 144:17  144:17 146:24,25,25  162:25 176:4,5,13,14  177:23 199:17 219:6  288:16 300:9 416:18  439:8  <b>glad</b> [1] 214:2  <b>goal</b> [1] 49:13  <b>goes</b> [18] 9:6 14:1 21:2  74:9 95:3 97:14 108:6  135:7 136:10 166:13,14  237:19 262:10 289:15  290:12 330:6 394:4 413:5  <b>gone</b> [15] 26:18 31:24  38:24 52:22 60:18 62:16  77:20 114:6 148:8 163:5  169:1 214:7,15 246:4  301:8  <b>good</b> [28] 4:6,6,9 60:16  98:2 123:1 125:15 127:23  133:23 211:24 231:20  246:21 260:15,17 265:6  265:11 271:25 277:24  293:8,19 323:20 324:4  335:12,17 337:10 395:24  452:24 453:24  <b>govern</b> [1] 284:25  <b>governing</b> [1] 428:24  <b>government</b> [6] 23:13  26:16 44:22 270:2 416:18  437:1  <b>Gown</b> [7] 415:21 419:14  419:15,24 422:2 425:12  425:18  <b>Gown's</b> [3] 420:3,8  426:20  <b>GP</b> [2] 62:21 69:19  <b>grain</b> [1] 388:6  <b>granted</b> [1] 393:20  <b>great</b> [4] 208:6 331:20  339:6 431:1  <b>greater</b> [5] 150:8 154:18  169:21 174:7 378:3  <b>greatest</b> [1] 30:1  <b>greatly</b> [6] 24:7 26:1  27:17,19 29:8 45:19  <b>Gregory</b> [1] 265:25  <b>Grenfell</b> [2] 272:2  276:20  <b>grey</b> [1] 302:16  <b>grounded</b> [1] 446:12  <b>group</b> [36] 31:13 33:25  69:18 79:12 93:21 116:24  120:8 130:22 132:25  137:22 145:9,13,22,24  146:14 154:9,10 156:2,7  158:2 160:1 199:16  206:25 210:3 225:3 235:2  309:11,17 313:17 317:12  402:10 417:9 432:4,15  456:1,22  <b>groups</b> [10] 21:14,17  25:18 29:7,9 46:3,5  129:7 154:13 157:24  <b>growth</b> [1] 48:21  <b>guard</b> [2] 298:4 339:12</p>	<p><b>guess</b> [103] 8:25 27:22  31:23 33:20 76:17 89:25  93:8 97:8,11 102:10  105:14 128:19 137:19  138:3,19 152:21 153:23  156:12 157:18 168:1  176:13 180:23 184:16  189:4,15 190:1,18 198:18  199:16 200:1 206:19  213:17 214:7,19 215:16  217:2,7 220:19 221:5  231:24 240:20 252:24  268:16 274:9 275:16  278:2 279:8,20 281:3  282:16 287:16 288:18,21  289:4 298:20 299:1  300:17 303:8 304:4,16  314:23 317:4 318:13  319:7,21 320:2,10 332:11  333:14 334:16 340:23,24  341:11 350:4 357:14  358:11 366:12 375:18  380:7 381:24 389:6  391:21 397:5 400:5  401:20 402:9 404:3,8,9  406:23 407:3 408:22  409:6,23 417:18 421:9  427:3 429:6 432:25  441:14,23 450:10 456:16  <b>guessing</b> [1] 34:7  <b>guests</b> [1] 115:6  <b>guideline</b> [6] 76:16  77:16,17 78:2,4 81:23  <b>guidelines</b> [12] 78:6  278:13,20,22 279:14  280:13 401:1,5 402:22  403:1,5 404:1  <b>Gulliver</b> [26] 50:9,21  74:11 104:25 108:17  110:25 111:2,11 114:10  115:7 122:3 226:9 227:17  228:17 231:6,9 232:20  252:17 254:6 311:21,22  319:9 322:4 358:12,15  421:23  <b>Gulliver's</b> [2] 419:6  421:13</p> <hr/> <p style="text-align: center;"><b>-H-</b></p> <p><b>H</b> [1] 220:2  <b>hair</b> [1] 48:21  <b>hall</b> [3] 112:15 146:17  354:22  <b>hand</b> [2] 44:9 350:4  <b>handle</b> [3] 336:2 348:8  397:13  <b>handled</b> [1] 276:13  <b>handling</b> [2] 331:13  346:1  <b>hands</b> [1] 30:2  <b>handwriting</b> [3] 5:2  110:13 417:19  <b>handwritten</b> [4] 69:3  110:24 118:9 311:10  <b>hanging</b> [1] 456:9  <b>Hanlon's</b> [1] 18:19  <b>happening</b> [7] 51:15</p>
--	---	--	--	---

<p>184:10 242:21 274:8 291:7,7 435:1 <b>happier</b> [1] 425:3 <b>happy</b> [2] 405:3 425:2 <b>hard</b> [7] 69:15 80:2 91:11 93:10 220:16 261:19 453:21 <b>harder</b> [1] 336:2 <b>Harkening</b> [1] 60:24 <b>harm</b> [3] 434:3 435:6 437:14 <b>hat</b> [4] 122:25 232:1 424:10,11 <b>hats</b> [1] 424:10 <b>hazards</b> [1] 437:13 <b>he'd</b> [1] 381:9 <b>head</b> [3] 143:23 301:14 456:9 <b>headed</b> [1] 224:22 <b>heads</b> [2] 212:8 293:12 <b>health</b> [109] 1:11,17 15:17 19:17,20 24:7 37:24 39:21,24 41:20 42:7 44:1,7,14,15,21 45:6 47:15,16 49:9 52:23 55:5 70:11,15 79:13 82:17 126:5 152:16 155:5 170:2 198:8 202:6 205:19 206:22 207:23 208:13 209:4,15 212:13 220:10 222:16 237:21,25 238:3 239:11 242:23 247:10 270:17 272:2,24 276:1 278:4,6 279:2,14,22 281:3,5,12 310:12 314:17 317:12,21 326:12 330:24 338:6 342:14,15 357:24 358:25 359:18 376:11 383:6 386:25 389:20 394:5,23 397:3,22 402:23 402:25 406:25 412:9 415:21 416:3,16,20,24 419:7 422:21,23 423:1 423:23 428:7 431:16,24 432:13 433:2 435:16,16 435:20,23 438:6,10 447:3 449:22 450:18 452:13 454:10 <b>Health's</b> [5] 51:15 202:24 234:19 241:3 279:6 <b>hear</b> [4] 189:14 190:2 213:16 422:14 <b>heard</b> [21] 53:1 57:19 59:8 62:11 88:22 100:4 100:15 111:2,11 175:4 188:7 190:6 202:20 212:10 213:2,14 268:24 313:5 398:9 433:18 458:5 <b>hearing</b> [14] 10:5 13:3 173:15 174:23 210:23 222:4,20 234:5,13 331:15 340:16 415:4,16,20 <b>hearings</b> [1] 407:13 <b>Heather</b> [34] 2:2 4:3 14:16 17:17 20:15 22:1 28:16,22 29:4,8,24 30:2 30:7 37:24 51:10,24 69:4</p>	<p>95:6 96:2 116:16 119:16 137:5 201:2,16 207:19 242:11 244:1,24 252:20 271:23 277:22 388:22 412:13 424:25 <b>Heather's</b> [1] 136:9 <b>held</b> [4] 63:25 93:21 235:23 438:25 <b>help</b> [6] 307:2,3 336:11 395:6,25 435:10 <b>helped</b> [1] 186:6 <b>helpful</b> [2] 30:7 346:8 <b>helping</b> [1] 123:19 <b>Henley-Andrews</b> [3] 267:22 268:9 270:3 <b>Hennebury</b> [1] 1:9 <b>Hennessey</b> [22] 8:13 12:5,8,20 13:3,13,15 14:7,10,17,24 15:18 17:15 19:19 20:10 37:25 38:6 51:12 53:24 54:7,8 55:11 <b>hereby</b> [1] 458:2 <b>herself</b> [2] 199:7 267:8 <b>hesitancy</b> [4] 443:9,12 443:18 444:3 <b>hesitant</b> [3] 442:22,24 443:2 <b>hesitate</b> [1] 8:18 <b>hesitation</b> [1] 443:4 <b>Hi</b> [5] 97:24 200:24 205:5 205:15 212:3 <b>HIC</b> [5] 205:22 207:8,24 208:19,19 <b>hide</b> [1] 215:7 <b>hiding</b> [2] 216:2 221:21 <b>high</b> [10] 78:15 154:10 201:25 304:6,7 342:8 388:13 406:24 430:17 451:24 <b>higher</b> [2] 84:3 304:9 <b>highlight</b> [1] 138:4 <b>highlights</b> [1] 380:14 <b>Hill</b> [3] 112:12 113:2,20 <b>hindsight</b> [3] 339:17 342:22 376:17 <b>hiring</b> [1] 122:5 <b>HIROC</b> [17] 393:23 395:10,13 396:5,8 423:19 423:21 424:8 434:9,11 435:23 436:14,20 437:6 437:23 438:4 439:7 <b>HIROC's</b> [1] 394:12 <b>historical</b> [1] 184:5 <b>history</b> [1] 100:1 <b>hoc</b> [1] 284:17 <b>hold</b> [3] 213:8 218:19 454:9 <b>hole</b> [1] 333:14 <b>holes</b> [1] 335:25 <b>holidays</b> [1] 245:18 <b>home</b> [12] 4:25,25 113:12 113:19 137:25 139:23 141:17,21 152:12 154:14</p>	<p>157:21 245:21 <b>Homes</b> [1] 431:23 <b>Honourable</b> [2] 1:3 458:6 <b>hope</b> [3] 137:6 236:16 319:21 <b>hopefully</b> [3] 275:11 330:18 339:6 <b>hopes</b> [1] 321:19 <b>hoping</b> [2] 317:14 318:8 <b>hormonal</b> [4] 75:7 366:8 367:16 421:2 <b>hormone</b> [3] 1:2 366:6 458:4 <b>hospital</b> [3] 226:24 227:2 329:24 <b>hospitals</b> [2] 206:20 437:2 <b>hot</b> [1] 223:23 <b>hotline</b> [3] 351:1,10 353:3 <b>hour</b> [6] 145:8 212:12 234:12 293:21 307:9 341:20 <b>hours</b> [1] 134:18 <b>house</b> [3] 68:11 165:24 234:11 <b>Howell</b> [37] 74:10 93:19 95:5 98:13 102:6 108:18 116:4 127:19 128:5 129:20 130:8 135:3,23 145:20 146:18 158:9,16 159:1,8,13 160:9,16 161:16 165:7 173:23 184:18 189:20 190:24 191:3 192:5 193:12 194:17 195:9,14 202:19 202:21 212:1 <b>Howell's</b> [2] 195:22 291:25 <b>human</b> [1] 332:4 <b>husband</b> [3] 62:2 68:2 362:14 <b>hypotheses</b> [1] 208:2 <b>hypothetically</b> [2] 423:13,15</p> <hr/> <p style="text-align: center;"><b>-I-</b></p> <hr/> <p><b>i.e</b> [1] 195:1 <b>idea</b> [30] 5:21 22:22 61:21 98:24 102:1 108:16 113:22 115:2 123:2 131:7 133:21 138:12 186:10 208:11 243:11 251:20 275:8 352:25 357:21,24 362:8 372:24 405:3,17 414:8 422:11,20 429:3 455:1,20 <b>ideal</b> [2] 125:1 299:2 <b>ideas</b> [1] 137:3 <b>identifiable</b> [1] 300:12 <b>identification</b> [4] 274:10 296:11 299:12 434:2 <b>identified</b> [35] 26:8</p>	<p>28:20 29:9,25 43:21 63:16 65:6 132:25 133:4 134:13 140:25 145:16 153:13 156:2 163:7 235:3 235:6,10 241:6 242:24 243:9 254:9 255:15 257:22 261:14 263:7,9 264:22 266:24 288:4 296:9 305:1 343:14 428:5 453:11 <b>identifies</b> [1] 363:6 <b>identify</b> [18] 31:25 64:15 65:1 154:15 246:6,7 295:18,23 298:2 299:15 304:7 305:4 306:24 307:12 365:2 391:19 402:8 445:16 <b>identifying</b> [7] 147:3 181:9 195:17 258:23 308:6 362:12 437:13 <b>ignore</b> [2] 145:13 445:2 <b>ignoring</b> [2] 444:21 445:8 <b>IHC</b> [8] 101:1,21 122:3 231:25 233:19 285:18 298:19 320:21 <b>imaginary</b> [1] 396:8 <b>imagine</b> [3] 72:3 242:2 454:16 <b>immediately</b> [5] 30:3 239:16 316:5 345:12 352:12 <b>immuno</b> [1] 316:13 <b>immunoperoxidase</b> [1] 315:8 <b>impact</b> [14] 31:16 33:24 82:12 146:23 147:4 153:1 153:5 287:16 302:23 303:22 306:7 350:16 394:13 444:5 <b>impacted</b> [29] 20:16 21:3 21:13,15 24:7,15 26:2 26:19 27:18,23 28:3,6,8 28:20 29:2,8 30:1 34:22 35:4 36:20 45:7,22,25 93:4 129:13 130:23 131:1 133:1 134:13 <b>impacts</b> [3] 19:2 48:6,15 <b>implement</b> [1] 52:9 <b>implementation</b> [3] 107:23 112:5 321:20 <b>implemented</b> [10] 49:13 107:14 117:19 119:19 120:10 126:16 289:1 299:3 318:22 409:15 <b>implementing</b> [3] 50:24 298:1 308:21 <b>implication</b> [2] 373:21 391:4 <b>implications</b> [2] 319:5 319:19 <b>importance</b> [4] 86:12 119:23 120:10 303:9 <b>important</b> [16] 54:17 64:23,25 119:19 124:11 273:17 295:20 299:14 303:17 305:12 307:13</p>	<p>308:7 380:14 390:15 391:18 419:11 <b>impossible</b> [1] 29:22 <b>impression</b> [13] 50:15 99:12 217:16 239:9 240:18 241:23 269:2 277:3 300:18 315:17 340:3 342:3 455:22 <b>improve</b> [1] 430:21 <b>improved</b> [6] 317:10,16 318:2,8 321:21 323:18 <b>improvement</b> [1] 327:1 <b>inaccuracy</b> [1] 54:9 <b>inaccurate</b> [1] 47:10 <b>inaudible</b> [4] 295:2 387:18 408:2 413:20 <b>incident</b> [10] 188:13,19 263:3 278:10 281:7 323:11 345:23 402:24 436:21,24 <b>incidents</b> [1] 402:19 <b>include</b> [10] 129:18 161:5 161:17 178:23 292:19 357:15 360:10 364:4 391:15 419:8 <b>included</b> [14] 6:18 17:20 31:18 47:8 63:5 115:7 130:10 132:24 188:18 227:9 359:13,15 368:13 369:18 <b>includes</b> [4] 327:9 361:2 390:19 419:6 <b>including</b> [11] 42:8 74:10 92:25 132:25 136:7 161:16 164:12 205:3 222:4 235:2 362:7 <b>inclusion</b> [2] 226:4 230:1 <b>incomplete</b> [2] 311:13 419:13 <b>incongruity</b> [2] 419:22 420:21 <b>inconsistent</b> [7] 41:6,20 317:11,16,22 319:23 321:22 <b>incorrect</b> [6] 46:14 53:22 235:16 301:8 302:10 303:7 <b>increase</b> [6] 155:11 240:13 389:13,14 422:8 433:21 <b>increased</b> [1] 240:11 <b>increases</b> [1] 422:13 <b>indeed</b> [3] 379:23 399:13 400:14 <b>Independent</b> [4] 440:4 440:5 442:6 455:12 <b>indicate</b> [9] 45:21 46:20 51:25 84:22 130:22 192:10 264:7 269:19 357:6 <b>indicated</b> [10] 15:8 21:22 37:23 55:4 102:5 119:25 227:20 238:3 319:13 324:9 <b>indicates</b> [4] 14:11 36:3 379:9 383:16</p>
--	--	--	--	---

<p><b>indicating</b> [4] 15:18 23:5 120:16 138:19</p> <p><b>indication</b> [3] 84:21 351:11 367:22</p> <p><b>indicators</b> [5] 78:1 292:6 292:11,12 431:1</p> <p><b>individual</b> [12] 136:23 142:1 147:25 178:10 239:19 275:1 283:24 335:14 336:12 337:2,24 400:12</p> <p><b>individuals</b> [10] 158:4 237:23 238:3 247:25 257:21 324:9 336:7 338:13 341:9 358:7</p> <p><b>industry</b> [3] 298:25 338:6 342:14</p> <p><b>inference</b> [2] 46:22 406:24</p> <p><b>infiltrating</b> [1] 262:16</p> <p><b>influence</b> [9] 274:6 303:10 306:9 307:6 376:4 439:6,12,21 451:5</p> <p><b>influences</b> [2] 84:12 157:23</p> <p><b>influencing</b> [2] 301:17 303:1</p> <p><b>info</b> [4] 14:15 207:22 414:18,24</p> <p><b>inform</b> [4] 76:12 136:14 235:6 409:9</p> <p><b>informally</b> [1] 314:22</p> <p><b>information</b> [176] 5:18 7:16 11:22 15:20 17:16 22:19 23:13 35:12 38:20 39:1,7 40:8,14,21,25 41:4,8 42:20,23 43:8 44:3 47:14,18,18 48:10 49:17 50:20 53:15,16,22 54:5,12,18 55:13 56:14 57:20 61:11 70:19 72:11 72:12 74:19 75:10 76:7 79:12 80:15 81:6 82:17 82:23 87:6 88:8,18 89:23 92:10,15 94:9,12 106:20 116:1 133:11,14 134:10 134:25 136:24 162:18 163:25 168:22 169:16 173:7,12 175:20,25 176:4 176:6,8,12,23 177:15,22 178:10,13 184:3 185:1 185:10 200:12 201:9,21 203:17 204:6,19 206:25 207:21 208:8,24 209:7 212:14 216:1,8,13 217:10 217:15,17 226:7 227:14 228:19 231:10,14 232:4 233:6 239:12 247:24 250:19 252:21 253:7,21 261:25 268:3,15 270:1,5 270:17 271:1,3 287:22 291:9 306:14 310:3,10 310:21,22 311:5,12,23 312:9,10 313:7 314:10 314:15 318:13 320:17 322:4 333:9 340:19 342:21 343:1,8,16 344:4 345:5,13 349:12 350:14 353:4 355:24 358:25</p>	<p>360:20 366:11 376:10 383:6 384:13 387:1 400:17 407:8,14,21 416:19 419:15 432:7 435:10 436:19 447:22 449:8 450:20,24 451:4 451:12 452:7</p> <p><b>informed</b> [14] 58:25 59:1 80:8 164:22 210:5 239:18 242:23 243:5,8 301:22 302:14 357:2 404:21 406:5</p> <p><b>infringe</b> [1] 181:5</p> <p><b>inherent</b> [1] 424:11</p> <p><b>inhibitors</b> [2] 156:11,23</p> <p><b>initial</b> [8] 22:15 24:10 45:10 264:14 301:22 307:8 311:25 456:23</p> <p><b>initiate</b> [3] 21:25 22:20 22:23</p> <p><b>initiated</b> [2] 23:8 45:3</p> <p><b>initiating</b> [1] 47:8</p> <p><b>Initiatives</b> [1] 126:15</p> <p><b>innocuous</b> [1] 246:14</p> <p><b>input</b> [5] 143:9 154:4 288:19 394:7 396:15</p> <p><b>inquest</b> [1] 433:10</p> <p><b>inquire</b> [3] 117:20 413:4 413:5</p> <p><b>inquired</b> [2] 270:4 350:18</p> <p><b>inquiries</b> [4] 103:3 117:15 248:17 346:15</p> <p><b>inquiry</b> [14] 1:1 68:1 193:3,6,9 206:7 260:10 413:22 414:12,17,21 440:5 458:4,7</p> <p><b>insisted</b> [1] 312:2</p> <p><b>instance</b> [6] 276:9 324:11,12,15,18 451:15</p> <p><b>instances</b> [4] 226:2,3 311:9 404:20</p> <p><b>instead</b> [3] 270:15 409:9 442:16</p> <p><b>Institute</b> [2] 403:1 433:16</p> <p><b>instituted</b> [1] 109:12</p> <p><b>institution</b> [2] 274:21 275:19</p> <p><b>institutional</b> [1] 329:4</p> <p><b>institutions</b> [1] 274:14</p> <p><b>instruction</b> [1] 393:6</p> <p><b>instructions</b> [2] 392:1 392:23</p> <p><b>insurability</b> [1] 394:14</p> <p><b>insurance</b> [7] 394:24 397:25 423:22,24 424:1 424:4 434:12</p> <p><b>insurer</b> [12] 390:24 392:2 392:11 393:6,23 427:12 427:20 434:10,12 444:12 444:19,22</p> <p><b>insurer's</b> [1] 392:22</p> <p><b>Integrated</b> [2] 1:10,17</p> <p><b>intended</b> [5] 37:2 52:9</p>	<p>198:14 314:3 440:19</p> <p><b>intense</b> [5] 11:9,11 28:2 242:3 318:10</p> <p><b>intensive</b> [1] 338:15</p> <p><b>intent</b> [4] 57:6 74:20 76:25 284:1</p> <p><b>intentions</b> [1] 121:6</p> <p><b>interaction</b> [2] 285:11 290:7</p> <p><b>interactions</b> [1] 393:23</p> <p><b>interest</b> [7] 333:16 334:9 371:22 372:3 422:22,23 423:17</p> <p><b>interested</b> [12] 87:3 331:15,19,20 332:18,21 333:4 339:20,22 371:12 455:25 457:11</p> <p><b>interesting</b> [1] 251:2</p> <p><b>interim</b> [3] 29:18 68:10 403:3</p> <p><b>internal</b> [13] 53:14 226:19 227:13 228:11,25 230:14 286:13,23 287:21 288:4,10 304:19 308:16</p> <p><b>interpretation</b> [1] 398:22</p> <p><b>interpreted</b> [1] 190:12</p> <p><b>interrogatories</b> [3] 224:9,10 231:7</p> <p><b>interrogatory</b> [2] 224:6 227:15</p> <p><b>interrupt</b> [3] 180:25 277:18 328:25</p> <p><b>interrupting</b> [1] 73:11</p> <p><b>interview</b> [1] 272:8</p> <p><b>interviewed</b> [5] 9:25 10:1,2 214:23 447:21</p> <p><b>interviews</b> [1] 235:23</p> <p><b>intimately</b> [1] 401:5</p> <p><b>introduced</b> [2] 173:25 184:19</p> <p><b>introduction</b> [1] 17:23</p> <p><b>investigated</b> [1] 377:10</p> <p><b>investigating</b> [4] 60:2 261:11,12 336:10</p> <p><b>investigation</b> [5] 192:16 372:6,7 373:6 376:5</p> <p><b>invited</b> [1] 98:25</p> <p><b>involve</b> [2] 92:1 327:6</p> <p><b>involved</b> [48] 52:19 62:8 93:24 95:9,13,20,23 98:19 108:2 112:4,8 115:10 122:17,22 123:2 123:8,19,25 126:15 127:4 160:2 165:10 198:22 199:2,16 205:20 208:5 257:9 260:8 266:24 273:14 282:1,10 292:20 297:25 310:22 312:13 324:10,16,18 334:13 358:5,8 427:20 436:3,13 446:13 456:22</p> <p><b>involvement</b> [5] 245:14 245:17 269:12 400:20 437:13</p>	<p><b>involves</b> [2] 117:9 427:17</p> <p><b>involving</b> [2] 78:7 91:17</p> <p><b>irrelevant</b> [1] 209:10</p> <p><b>issue</b> [61] 16:7,18 17:19 43:14 44:11 50:17 84:10 93:22 94:15 101:25 102:7 107:4 136:18 142:21 166:1 169:6 180:12 182:7 183:24 185:2 201:2,25 203:5 211:15 213:22 232:3 247:23 249:12 259:1 260:2,24 261:1 266:17 272:16 273:18 274:20 276:20 282:2,10 283:11 286:24 288:5 296:11 310:18 312:20 332:16 335:23 336:12,13 343:24 367:8 388:25 392:15,18 393:1 394:20 395:3 400:15 424:7 451:6 456:11</p> <p><b>issues</b> [34] 11:6 16:2 139:17 145:15 153:12 154:23 200:14 214:19 226:18 239:15 264:25 265:2,4 274:10 284:6 286:15 287:1 298:2 309:13 310:10 342:9,17 389:23 390:9,25 391:3,8 391:10,14 393:4 431:2 432:6 433:1,15</p> <p><b>item</b> [3] 393:24 394:14 422:15</p> <p><b>items</b> [3] 394:8 418:5 449:17</p> <p><b>itself</b> [2] 310:25 349:21</p>	<p>437:21 441:6</p> <p><b>jump</b> [1] 440:1</p> <p><b>June</b> [21] 51:6 102:19,25 105:4,11 106:18 108:23 109:23 110:6,10,11 111:9 122:10 234:4 236:19 261:6 265:12 383:5 393:19 394:6 395:2</p> <p><b>justice</b> [3] 1:3 139:23 458:6</p> <hr/> <p style="text-align: center;"><b>-K-</b></p> <p><b>Kara</b> [7] 1:9 74:12 75:3 188:11,12 192:10 384:2</p> <p><b>keenly</b> [1] 210:18</p> <p><b>keep</b> [10] 61:25 77:23 107:13 139:20 234:5 287:1 290:21 292:15 311:11,15</p> <p><b>keeping</b> [3] 27:1 182:11 370:9</p> <p><b>kept</b> [2] 240:12 297:9</p> <p><b>key</b> [16] 116:24 213:17 220:20 221:13,14 222:20 241:2 296:7 305:14,17 311:5 312:9 320:24 321:14 394:7 432:14</p> <p><b>kind</b> [17] 58:20 88:8 100:4 101:25 106:12 121:4 124:10 147:1 155:13 289:8 303:10,17 305:18 320:18 391:4 403:16 452:12</p> <p><b>knew</b> [23] 12:3,8 50:20 50:21 51:2 53:10 126:10 155:10 157:12 161:8,23 164:16 207:23 217:9 221:1,7 223:14 241:15 243:11 245:19 253:18 406:25 409:19</p> <p><b>knowing</b> [7] 6:13 22:17 87:4 350:15 356:6,14 456:1</p> <p><b>knowingly</b> [1] 36:22</p> <p><b>knowledge</b> [10] 16:7 48:23 49:5 83:9,18 153:14 202:6 337:16 341:10 372:8</p> <p><b>knowledgeable</b> [2] 325:19 342:15</p> <p><b>known</b> [23] 22:13 34:9 36:10 53:16,19 87:5 88:8 161:9,15 164:18 171:7 190:21,24 298:24 310:4 327:18 330:2 338:6 342:24 353:24 362:3 363:23 439:19</p> <p><b>knows</b> [6] 81:2 213:19 220:21 222:2,23 313:19</p> <p><b>Kwan</b> [2] 195:5 196:11</p> <hr/> <p style="text-align: center;"><b>-L-</b></p> <p><b>lab</b> [73] 41:5 47:9 52:9 68:6 98:17 101:1,21,24 102:18 104:10 111:16 112:6 114:22 117:13 118:24 119:4 121:17</p>
--	--	--	---	---

<p>122:6 123:6,8 125:13,14 125:23,25 126:11 127:10 143:9 148:6,22 150:11 179:1 199:18 227:2,11 227:11 251:25 286:14,14 287:21 290:1,1 291:25 300:25 301:1,2,4,9,13 301:22 303:5,6 304:11 316:13 317:24 318:2,22 318:24 322:3,11 325:8 325:25 357:19 371:12 372:3 373:23 374:8 375:18,21,24 376:4 377:9 377:18 380:1</p> <p><b>lab's</b> [3] 227:4,19,22</p> <p><b>laboratory</b> [10] 49:11 49:14 52:20 124:4,9,25 296:17 300:19 304:19 320:22</p> <p><b>Labrador</b> [5] 17:22 42:22 431:16 458:8,11</p> <p><b>Labrador-Grenfell</b> [1] 1:16</p> <p><b>labs</b> [2] 272:16 371:22</p> <p><b>lack</b> [7] 33:23 124:8 126:7 226:19 323:10 337:16 376:20</p> <p><b>lady</b> [16] 61:21 62:1,5 64:15 69:4 81:19 82:16 86:19 188:5,9,22 190:4 192:11 333:9 356:25 407:11</p> <p><b>lady's</b> [1] 409:16</p> <p><b>laid</b> [1] 133:19</p> <p><b>Laidley</b> [5] 123:13 261:25 262:3 267:6 289:25</p> <p><b>Laing</b> [23] 1:9 56:16 59:19 64:9 74:12 88:20 115:8 165:9 184:17,19 188:11 193:13 346:8 347:5,11 348:10 349:16 355:19 408:19 409:15,17 438:25 456:11</p> <p><b>Laing's</b> [8] 69:5,7 188:4 188:22 190:4 258:7,8 259:15</p> <p><b>language</b> [1] 287:15</p> <p><b>large</b> [6] 92:24 280:24 282:9 286:3 400:8 456:1</p> <p><b>larger</b> [5] 59:5 78:9 145:9 402:19 418:13</p> <p><b>last</b> [21] 9:2 17:21 110:1 188:5 205:16 213:10 223:8 225:13 249:23 260:14,19 317:8 326:5 332:12 339:18 406:20 409:10 415:3 417:4 422:15 425:14</p> <p><b>lasted</b> [1] 341:20</p> <p><b>late</b> [10] 84:7 103:16 104:21 124:6 247:18 254:18,23 255:14 322:8 443:19</p> <p><b>latest</b> [7] 97:11 127:24 129:23 130:2 194:15 195:10,13</p> <p><b>law</b> [7] 115:25 163:6</p>	<p>175:17 178:6 245:24 246:2,16</p> <p><b>lawsuit</b> [4] 46:19 89:12 136:19 219:7</p> <p><b>lawyer</b> [2] 47:7 212:7</p> <p><b>lawyers</b> [1] 212:13</p> <p><b>lays</b> [1] 283:20</p> <p><b>leader</b> [1] 123:7</p> <p><b>leadership</b> [3] 126:25 127:9 188:21</p> <p><b>leading</b> [3] 165:1 186:22 409:12</p> <p><b>learn</b> [5] 289:11 308:5 350:9 352:18 431:2</p> <p><b>learned</b> [9] 320:22 321:6 321:12,18 322:3 341:16 341:21 395:11 433:12</p> <p><b>learning</b> [3] 309:23 310:3 354:17</p> <p><b>least</b> [14] 12:4 20:20 91:2 98:7 106:12 167:22 182:24 246:20 250:7,8 313:18 314:8 335:6 342:7</p> <p><b>leave</b> [5] 46:22 69:6 241:1 263:17 425:4</p> <p><b>leaves</b> [2] 288:9,11</p> <p><b>leaving</b> [1] 277:2</p> <p><b>led</b> [3] 333:11,12 440:5</p> <p><b>left</b> [15] 7:2 8:16,21 50:15 68:10 91:18 202:6 217:15 220:15 239:9 277:3 302:2 341:11 343:11 441:12</p> <p><b>left-hand</b> [1] 418:5</p> <p><b>leg</b> [1] 48:17</p> <p><b>legacy</b> [1] 435:21</p> <p><b>legal</b> [21] 18:17 19:17 21:25 23:8 43:14 45:2 47:15,16 55:4 96:2 182:12,14 183:3 199:24 212:19 246:9 249:1,1 390:20 423:14 446:9</p> <p><b>legally</b> [1] 201:13</p> <p><b>legislation</b> [3] 206:23 208:8,10</p> <p><b>lend</b> [1] 310:25</p> <p><b>lengthy</b> [3] 237:19 257:15 342:13</p> <p><b>Leona</b> [3] 70:10 129:19 189:21</p> <p><b>LeRiche</b> [1] 453:12</p> <p><b>less</b> [17] 62:13 125:1 199:5 370:25 375:20,23 376:24,25 377:25 379:13 379:13 410:6 417:10,11 417:12 451:23 453:16</p> <p><b>lets</b> [1] 210:11</p> <p><b>letter</b> [113] 62:21 68:24 75:15 76:2 77:22,24 78:22 79:5,8,10 80:8,12 80:13,17,22 81:10,17,18 81:22 82:1,6 83:5 87:2 87:12,25 88:17,19,25 89:1,13,17 92:7,14 188:11,16,25 189:23 195:19 198:1,1,9,14 210:15 236:15,18 245:3</p>	<p>245:6,14 246:1,5,10,11 246:13 247:11,11,12,15 247:22,25 248:7,12,18 248:22 249:5,14,25 251:9 263:15 267:25 268:2 270:3,16 315:3,5,14,25 316:2,25 317:5,6 318:15 318:23 319:8 322:7 345:10 348:9 365:19 367:14 383:19 384:8 393:8 396:16,25 398:11 398:11,24,25 399:5,13 410:4,8,15,16,20 440:8 440:12,18,19 441:5 442:17 443:5,10,23</p> <p><b>letters</b> [18] 80:17 82:2 88:12 89:4 245:9 247:19 250:3 348:2,3 356:19 364:23,23 365:6 377:24 383:12 385:22 386:16 441:19</p> <p><b>level</b> [27] 28:2 85:1,12 87:22 93:2 125:17 143:14 143:15 163:5,10,13 166:4 168:17,24 208:25 291:6 304:9 331:20 334:16,20 338:5 342:8 385:2 388:14 404:10 406:25 433:21</p> <p><b>levels</b> [3] 155:12 264:12 429:7</p> <p><b>Lewis</b> [4] 23:9,23 43:21 43:24</p> <p><b>liability</b> [4] 392:2 430:2 430:3,10</p> <p><b>liberty</b> [1] 169:5</p> <p><b>lie</b> [1] 127:11</p> <p><b>life</b> [2] 74:5 382:5</p> <p><b>lift</b> [1] 388:16</p> <p><b>light</b> [7] 211:11 318:13 322:2 340:23,25 342:21 382:13</p> <p><b>liked</b> [1] 130:8</p> <p><b>likelihood</b> [1] 30:1</p> <p><b>likely</b> [11] 21:24 22:7 29:6,7 44:2,8 81:3 140:10 195:23 329:25 384:22</p> <p><b>limit</b> [1] 306:25</p> <p><b>limitations</b> [1] 161:8</p> <p><b>limited</b> [8] 39:19 136:20 178:6 206:21 366:12 372:8 389:15,18</p> <p><b>line</b> [28] 39:22 96:20 117:1 122:15 125:14 197:20 213:9 218:19 245:21 246:18 251:3,13 252:6 261:20 292:15 371:4 372:25 373:10 376:24 377:22 378:2,8 378:18 380:11,20 383:14 385:20,25</p> <p><b>lines</b> [7] 13:7 45:6 310:17 378:23 380:19 386:3,14</p> <p><b>link</b> [1] 290:2</p> <p><b>linked</b> [5] 23:10 123:7 289:25 394:15 435:22</p> <p><b>list</b> [50] 3:1 28:22 30:3 32:5,9,10,11 34:16 36:11</p>	<p>63:4 64:25 67:9 94:9 106:16 108:22 109:4,13 109:15 110:19 188:14,20 188:22 190:4 194:24 196:9 236:2,3,7 246:19 246:24 252:19,20 253:1 253:3 255:21 257:18 296:25 347:17 354:20 360:18,22 361:13,16,25 363:15 381:19 383:14 384:2,13 448:18</p> <p><b>listed</b> [4] 69:20 147:24 231:21 254:12</p> <p><b>listen</b> [1] 214:10</p> <p><b>listening</b> [4] 34:11 214:22 313:6 372:8</p> <p><b>lists</b> [8] 360:15 363:11 365:20 370:15 376:23 377:24 380:10,24</p> <p><b>literature</b> [1] 305:14</p> <p><b>litigation</b> [2] 391:15,23</p> <p><b>living</b> [2] 362:13 381:17</p> <p><b>lobular</b> [1] 310:19</p> <p><b>local</b> [1] 201:7</p> <p><b>locate</b> [8] 325:23 376:22 380:23 383:18,20 385:22 386:16 412:25</p> <p><b>located</b> [3] 364:24 378:22 424:3</p> <p><b>locating</b> [1] 416:22</p> <p><b>log</b> [1] 292:13</p> <p><b>logistical</b> [1] 399:5</p> <p><b>logistics</b> [3] 247:15 283:5 398:24</p> <p><b>longer</b> [8] 69:17 105:25 251:11 266:16 360:18 361:20 363:1 383:13</p> <p><b>look</b> [56] 5:23 8:2,10 9:10 20:8 23:4 34:17 35:13 42:25 51:4 66:12 67:24 70:8 86:1 96:16 109:19 118:5 124:5 127:13 129:16 131:24 132:2,5 134:17 135:6 144:3 151:3 151:16 200:21 203:11 219:13 240:25 241:20 276:24 287:6 289:9 297:8 297:16 299:4 302:18 304:5 336:17 362:19 368:20 381:19 385:19 387:10 397:17 403:13 404:3 409:23 410:14 413:16 416:2 434:23,24</p> <p><b>looked</b> [11] 29:5 53:12 63:8,24 64:3 66:5 76:7 144:12 154:19 374:18 421:14</p> <p><b>looking</b> [28] 21:5 29:3 85:24 112:13 113:14,14 203:20 208:4,15,23 216:7 305:24 309:4 318:23 339:17 353:8 358:2 370:12 374:9,10 379:16 380:11,16 389:12 397:16 402:10 414:18 441:24</p> <p><b>looks</b> [12] 18:4 24:20 30:12 129:21 130:2,3 132:18,19 197:13 216:1</p>	<p>219:6,13</p> <p><b>loop</b> [1] 349:23</p> <p><b>Lorraine</b> [2] 213:3,24</p> <p><b>lose</b> [2] 394:24 397:25</p> <p><b>losing</b> [1] 392:3</p> <p><b>loss</b> [2] 392:14,18</p> <p><b>lost</b> [3] 69:21 399:22,24</p> <p><b>lots</b> [2] 148:20 393:3</p> <p><b>Louise</b> [6] 205:3,15,16 257:16 258:9 259:8</p> <p><b>low</b> [4] 13:25 154:9,10 365:15</p> <p><b>lower</b> [1] 414:5</p> <p><b>loyalty</b> [4] 397:24 423:18 423:19,25</p> <p><b>lumpectomy</b> [1] 408:13</p> <p><b>LUNCH</b> [1] 211:20</p> <p><b>luncheon</b> [1] 209:21</p> <hr/> <p style="text-align: center;"><b>-M-</b></p> <p><b>MAC</b> [1] 116:25</p> <p><b>machine</b> [4] 228:5 319:10 325:15,24</p> <p><b>mad</b> [1] 79:22</p> <p><b>magnitude</b> [2] 282:19 283:4</p> <p><b>mail</b> [10] 193:16 210:14 210:15 213:10 220:15 221:5 222:7 247:9 260:8 362:17</p> <p><b>mailed</b> [1] 112:18</p> <p><b>main</b> [3] 231:10 430:19 433:7</p> <p><b>maintain</b> [1] 121:1</p> <p><b>maintained</b> [2] 121:4 121:15</p> <p><b>Majesty</b> [1] 1:8</p> <p><b>major</b> [4] 116:25 117:3 316:13 342:4</p> <p><b>majority</b> [3] 89:16 90:3 256:11</p> <p><b>makes</b> [5] 81:1 168:1 212:14 334:17 335:22</p> <p><b>man</b> [1] 247:17</p> <p><b>management</b> [1] 428:24</p> <p><b>management</b> [30] 115:6 116:14 117:14 119:15 120:1 122:17,24 127:5 273:15 390:7,8,14 397:5 427:4,4,10 429:18 430:6 430:14,20,21 431:4,10 432:10 433:4 434:4,17 434:21,25 436:11</p> <p><b>manager</b> [8] 107:19 163:22 297:9 424:10,15 427:2,10 432:3</p> <p><b>managers</b> [4] 428:24 431:15 432:5,13</p> <p><b>managing</b> [1] 390:19</p> <p><b>mandated</b> [1] 437:1</p> <p><b>Mandy</b> [1] 453:12</p> <p><b>manner</b> [4] 199:2 237:5 313:13 438:7</p>
--	--	--	--	--



Inquiry on Hormone Receptor Testing

<p><b>manual</b> [2] 325:25 403:21</p> <p><b>March</b> [5] 69:1,9 197:20 224:14 413:6</p> <p><b>Margaret</b> [1] 458:6</p> <p><b>Marian</b> [10] 197:19 198:17 199:7 200:22,24 200:24 205:2,17 245:4 246:6</p> <p><b>Marilyn</b> [3] 28:23 38:1 38:22</p> <p><b>mark</b> [8] 1:14 202:20 203:15,16 370:13 379:16 381:19 422:16</p> <p><b>MARKED</b> [1] 295:14</p> <p><b>marks</b> [1] 30:18</p> <p><b>mass</b> [3] 400:3 402:2 404:6</p> <p><b>mastectomy</b> [2] 262:12 366:2</p> <p><b>material</b> [2] 234:8,20</p> <p><b>materialized</b> [1] 437:15</p> <p><b>materials</b> [1] 30:4</p> <p><b>maternity</b> [1] 263:16</p> <p><b>math</b> [3] 137:17 202:12 202:13</p> <p><b>matter</b> [19] 169:4 177:12 178:18 299:20 312:3 314:18,21 327:23 340:17 375:10,14,18 400:21 416:11 423:15 451:23,25 454:20 458:3</p> <p><b>matters</b> [5] 184:6 445:17 445:18,22 455:8</p> <p><b>may</b> [123] 4:21 6:10 12:7 16:16 23:15,17 30:3,4 30:13 31:16 33:24 41:5 44:5 47:6 49:1 62:12 70:23 73:22 83:11 109:20 110:10,25 112:8 113:17 136:17 154:17 155:8,21 155:23 157:12 171:7 179:7 186:8,9 194:8 197:2,4 200:12,13 202:2 203:12 210:9,24 211:5 211:25 218:3 220:12 221:25 222:3 223:8 224:3 224:16 225:4,18 230:6,7 230:21,25 231:13 232:2 234:11 237:24 238:7,12 238:25 243:10 252:12 253:11 276:10 280:7 290:7,16 291:13 302:2,3 304:2,3,12 312:20 316:17 322:8,8 328:3 330:10 334:20 335:20 337:2 338:4 342:24 348:5,6 360:19 368:5,7 369:17 370:20 371:16 376:23 377:14,17 378:11 379:5 379:21 383:5 384:16 385:1 386:2,7 393:21 394:22 400:15,16 404:8 406:18 412:23 413:1,8 415:2,10 416:11 422:18 424:3 454:21</p> <p><b>McCarthy</b> [19] 262:18 263:12,16 346:6 347:25</p>	<p>348:9,23 349:4,19 350:11 350:17,25 351:8,25 352:8 352:17 354:2 355:14 439:1</p> <p><b>McCormack</b> [23] 12:24 13:12,14 15:19,23 17:14 18:21 19:19 20:10,19 25:11 29:6 38:1,22 40:7 41:9 42:12 49:17 50:3 50:13 51:5 54:11 55:12</p> <p><b>McKelvey</b> [1] 199:25</p> <p><b>mean</b> [35] 8:20 11:17 14:2 30:9 34:2,9 50:20 54:1 64:3 99:8,9 143:19 151:25 161:9 169:19 185:6 208:15 218:13 227:21 289:3 291:14 328:2 337:1 343:14 346:19 356:16 358:19 371:10 375:20 378:12 411:19 414:1 415:14 422:25 451:17</p> <p><b>meaning</b> [2] 5:18 228:25</p> <p><b>means</b> [7] 127:25 128:3 135:11 146:13 220:3 395:7 458:10</p> <p><b>meant</b> [12] 81:11,18 128:6 134:10,11,15,17 134:23 135:17 287:22 331:9 388:17</p> <p><b>Meanwhile</b> [1] 62:1</p> <p><b>mechanics</b> [1] 281:20</p> <p><b>media</b> [47] 43:20 63:9 70:22 74:22 75:24 77:5 138:16,21 145:25 146:7 163:7,17 166:6 167:9 168:5,21 169:2 175:18 179:14 180:13 184:24,25 186:22 195:2,10 210:24 212:2,17 213:20,23 214:5 214:5,17 215:24 218:13 220:22 221:10 234:5,7 234:13,19 235:23 237:21 238:1 239:3 240:18 352:3</p> <p><b>medical</b> [12] 1:14 42:8 116:21,23 117:2,5,9 127:10 222:11 349:4 394:10 408:18</p> <p><b>medication</b> [3] 304:5 433:16,19</p> <p><b>medications</b> [2] 304:11 409:8</p> <p><b>medicine</b> [1] 296:17</p> <p><b>Meditech</b> [1] 227:7</p> <p><b>medium</b> [1] 174:7</p> <p><b>meet</b> [13] 56:15 59:19 75:14,18 192:11 211:19 261:13 268:25 269:23 354:3 360:4 394:5 432:10</p> <p><b>meeting</b> [60] 36:5,7 74:20 75:3 77:11 93:19 93:20,21,24 98:3,7,12 98:13 99:1,10 100:20 102:12 104:22 106:22 108:11,18 115:5 127:22 137:3 145:23 146:3,4,6 180:6,12 182:8 183:18 213:11 224:22 225:3 249:21,23 254:8 265:12</p>	<p>268:20 269:19 277:2 319:15 335:6 341:18 349:18 359:3 393:19,24 394:19 398:10 431:25 438:25 439:5 440:3,7 442:14 443:22 444:6 457:11</p> <p><b>meetings</b> [8] 34:21 74:23 225:7 310:24 311:12 319:9 335:5 349:22</p> <p><b>member</b> [6] 56:12 212:7 337:15 395:9,13 435:10</p> <p><b>members</b> [11] 1:12 15:16 37:20 57:18 146:14 212:22 299:14 309:11,17 385:5 436:6</p> <p><b>memo</b> [5] 86:20 231:22 232:10 233:21 413:8</p> <p><b>Memorial</b> [1] 453:2</p> <p><b>memory</b> [26] 7:10 9:6 9:19 10:10 12:25 16:9 17:6 18:24 19:23 20:22 44:5 55:10 102:1 146:16 165:11,13 177:18 182:5 187:25 204:5 259:19 315:16 326:1 355:13 370:3 398:14</p> <p><b>memos</b> [2] 232:6 233:15</p> <p><b>men</b> [1] 209:13</p> <p><b>menopausal</b> [1] 156:7</p> <p><b>mention</b> [3] 205:18,21 241:24</p> <p><b>mentioned</b> [10] 9:21 37:1 131:18 141:20 155:7 247:14 266:8 297:24 372:12 449:21</p> <p><b>mentioning</b> [2] 34:14 240:13</p> <p><b>message</b> [12] 159:10 213:15 237:25 238:18 400:5 437:22 438:15 439:4 442:11,13 443:14 454:18</p> <p><b>messages</b> [4] 68:10 186:25 311:1 394:7</p> <p><b>met</b> [14] 67:10 97:24 103:18 105:8 114:17 200:10 288:20 350:20 360:2 366:4 405:2,12 409:10 450:19</p> <p><b>metastases</b> [7] 25:3 26:20 31:8,10,18 32:1 408:24</p> <p><b>metastatic</b> [4] 14:3 29:13 37:7 366:8</p> <p><b>method</b> [3] 298:19 346:15 347:12</p> <p><b>Michaels</b> [4] 213:3,24 214:4,21</p> <p><b>Michelle</b> [1] 18:19</p> <p><b>mid</b> [2] 315:4 322:8</p> <p><b>middle</b> [3] 107:19 210:24 220:11</p> <p><b>might</b> [73] 29:20 42:10 57:12 63:10 75:24 84:23 95:20 101:20 114:9 118:13 150:8 166:18</p>	<p>173:3 182:25 200:3 218:3 218:4 273:4 285:12 287:13 291:5 292:18 295:24 298:3,15 301:7 301:21 302:22 303:2 304:14 307:6,24 308:17 309:3 310:3,25 316:16 319:21 323:3 329:1 337:5 337:23 338:5 339:5,11 340:17 342:23 348:4,16 349:2 350:14 351:10 352:12,18 355:24 356:6 359:14 361:4 366:23 371:25 373:20 374:12 375:22 376:3,12 377:5 381:23 383:22 393:8 422:21 436:23 456:22,23</p> <p><b>Miller</b> [2] 358:10 359:2</p> <p><b>mind</b> [16] 39:18 112:21 125:7 155:1 162:15,20 187:10 206:1 257:5 273:16 284:8 320:10 370:10 389:6 405:10 447:17</p> <p><b>mindset</b> [1] 402:24</p> <p><b>mine</b> [3] 48:1 146:20 166:12</p> <p><b>minimal</b> [1] 245:17</p> <p><b>minimize</b> [2] 430:1,2</p> <p><b>minimizing</b> [2] 430:3,4</p> <p><b>minister</b> [23] 9:10 10:9 12:4 96:21,25 97:15 127:22 128:23,25 132:7 136:1 147:7 149:6 153:4 165:17,23 212:11 393:24 393:25 394:5 414:17 416:20,23</p> <p><b>minor</b> [1] 452:20</p> <p><b>minute</b> [2] 286:4 437:20</p> <p><b>minutes</b> [16] 79:20 134:1 145:7 215:18 224:5,23 231:17,20 265:13 269:18 277:16,18 313:16 314:4 388:19 422:16</p> <p><b>mis</b> [1] 75:16</p> <p><b>mis-communication</b> [1] 310:25</p> <p><b>mis-diagnosed</b> [2] 75:25 77:13</p> <p><b>misconstrued</b> [1] 171:14</p> <p><b>misdiagnosis</b> [2] 23:9 45:4</p> <p><b>misinterpretation</b> [2] 374:19 375:12</p> <p><b>mislabelling</b> [3] 300:10 300:11,11</p> <p><b>mislead</b> [2] 215:8 217:11</p> <p><b>misled</b> [3] 212:15,17 217:4</p> <p><b>misread</b> [1] 374:3</p> <p><b>miss</b> [1] 67:17</p> <p><b>missed</b> [14] 61:21 65:4 66:9 187:18 192:12,12 194:22 195:14,23 255:2 255:18 327:25 399:20 400:16</p>	<p><b>mistake</b> [3] 235:20 270:19 327:18</p> <p><b>mistaken</b> [1] 252:12</p> <p><b>mistakes</b> [6] 329:23,25 330:2 332:4 341:6,13</p> <p><b>misunderstanding</b> [1] 311:21</p> <p><b>misunderstood</b> [2] 314:4 340:1</p> <p><b>mitigate</b> [1] 330:19</p> <p><b>mode</b> [3] 116:19,19 432:16</p> <p><b>model</b> [4] 328:8,10 331:3 331:6</p> <p><b>modelling</b> [1] 155:9</p> <p><b>modes</b> [2] 297:20 338:16</p> <p><b>Module</b> [1] 434:21</p> <p><b>Moirra</b> [6] 8:13 12:5 37:24 51:10 53:10 54:3</p> <p><b>moment</b> [6] 75:8 181:1 215:22 219:15 411:22 416:15</p> <p><b>Monday</b> [11] 62:5,10 95:4 98:2 103:6,18 104:22 106:22 293:13,15 293:19</p> <p><b>monitor</b> [1] 120:23</p> <p><b>monitored</b> [2] 119:21 119:23</p> <p><b>monitoring</b> [4] 119:20 120:11 316:4,4</p> <p><b>month</b> [6] 116:23 122:14 209:15 240:11,14 403:12</p> <p><b>monthly</b> [2] 352:25 432:11</p> <p><b>months</b> [11] 204:21 349:2,10,11 352:13 356:6 356:21,21,22 362:10 404:22</p> <p><b>morning</b> [13] 4:6,6,9 55:24 103:7,18 104:22 106:22 127:16 143:24 217:22 267:21 457:19</p> <p><b>morning's</b> [1] 254:7</p> <p><b>Morris-Larkin</b> [1] 286:7</p> <p><b>Moss</b> [2] 458:2,13</p> <p><b>most</b> [29] 18:8 20:16 21:2 21:13,15 24:15 28:8 29:2 29:6,8 36:20 42:23 44:8 45:21 75:1,4 76:3 82:9 87:13 90:15 103:11 105:5 109:14 140:10 188:12 252:25 384:22 404:3 455:23</p> <p><b>Mount</b> [21] 22:16 24:13 30:11 36:7 42:19 45:11 49:16 68:6 116:22 151:17 201:7 243:2 254:10 310:12,17 314:16 344:14 359:20 365:25 409:3 440:13</p> <p><b>mouse</b> [1] 404:4</p> <p><b>move</b> [6] 222:13 250:6 335:21 374:7 394:11 452:21</p>
---	---	---	---	--

<p><b>moved</b> [4] 69:14,16 193:16 407:7</p> <p><b>movement</b> [1] 329:22</p> <p><b>moving</b> [2] 203:14 456:5</p> <p><b>MRI</b> [1] 320:11</p> <p><b>Mrs</b> [5] 23:8 113:11 246:13 247:6 408:11</p> <p><b>Ms</b> [1658] 2:2 4:2,3,6,8 4:11,13,20,21 5:9,14,20 6:5,12,20 7:4,8,18,19,24 8:4,7,14,14,23 10:17,21 11:8,14,20 12:6,8,13,20 12:22,24 13:3,8,12,13 13:13,14 14:7,10,17,19 14:24 15:5,10,18,18,22 15:24 16:5,15,24 17:5 17:10,14,14 18:13,20,22 19:5,12,19,19,22 20:5,9 20:10,18,21 21:4,11,19 22:4,9 23:1,14,22,24 24:3,17,25 25:11,14 26:5 26:23 27:3,8,14,20 28:9 29:6 30:15 31:7,21 32:6 32:17,24 33:7 34:6,24 35:5,10,18,24 36:14,21 37:3,9,14,18 38:4,6,11 38:15,25,25 39:2,4,6,15 40:1,3,7,11,15,16,17,22 40:23 41:9,10,16,23 42:3 42:11,13 43:4,10,17,23 44:4,17,24 45:13,23 46:13 47:1,19,25 48:9 48:13 49:4,17,18,23 50:3 50:7,13,18 51:4,12,17 52:24 53:24 54:5,7,8,10 54:10,14 55:9,11,12,17 55:21 56:4,10,23 57:5 57:15,22 58:4,10,16,22 59:2,11,17,23 60:8,9,15 60:20 61:5,15,19,20 62:21 63:6,22 64:5,12 65:2,9,17,22 66:4,11,17 66:23 67:5,11,18 68:2 68:15,18,20 69:13 70:1 70:5,20,21 71:3,6,10,15 71:19,23 72:1,2,7,10,14 72:15,17,19 73:5,14,21 74:4 75:12 76:15 77:7 77:19 78:3,14 79:2,7,15 80:1,10,19 81:4,15,25 82:8,18,22 83:14,20,24 84:4,25 85:9,17,21 86:3 86:9,14,18,21 87:8,17 87:23 88:3,9,15 89:10 90:6,12,17 91:3,7,9,22 92:2,6,16,21 93:7,23 94:2,7,14,18,19,20,23 95:12,16,22 96:5,13 97:2 97:7,18,23,23 98:10 99:5 99:14 100:6,11,16,22 101:2,5,5,10,22 102:13 102:22 103:4 104:1,6,11 104:15,19 105:7,22 106:2 106:19 107:6,15,24,24 108:15,25 109:8,16 110:3 110:7,14,20 111:1,7,17 111:21 112:2,10,22 113:1 113:5,9,19,21 114:3,11 114:16 115:12,17 116:10 117:4,21 118:3,11,18 119:3,11 120:3,13,18,24 121:19 122:1,20 123:4</p>	<p>123:12,16,21 124:3,13 125:2,10 126:9,19,23 127:8,15 128:1,7,13,18 129:1,9 130:3,7,12,17 131:2,6,15,21 132:1,9 132:13,17 133:6,13,20 134:4 135:1,12,18 136:2 136:6 137:13,17 138:8,9 138:13,14,25 139:3,6,11 140:2,5,17,20,21 141:3 141:9,14 142:3,10,20 143:24 144:3,5,21,22,25 145:2,10,17 146:2,9,15 146:18 147:8,13,22 148:12,19 149:7,14,22 150:2,13,18 151:8,12 152:2,6,23 153:17 154:1 154:24 155:20,24 156:24 157:5,9,17 158:8,12,17 158:21,25 159:9,15,22 160:5,11,18,22 161:2,7 161:21 162:2,14,21 163:3 163:15,20 164:6,15,23 165:3,8,19 166:2,3,11 166:20,24 167:7,17,25 168:11,15,23 169:7,11 169:17,23 170:8,15,24 171:6,16,21 172:1,6,11 172:16,21 173:9,16,21 173:22 174:8,13,20 175:1 175:6,10,14,22 176:2,11 176:18,24 177:3,8,13,25 178:4,9,14,20 179:2,4,9 179:16,22 180:3,6,8,16 180:21 181:4 182:13,18 183:4,10,14,20 184:7,12 185:5,11,22 186:13,17 187:5,11,16,22 189:2,12 189:25 190:8,17,25 191:8 191:16,21,23 192:7,13 192:18,25 193:5,11,23 194:1,4,11,18 195:12,24 196:3,12,18,22 197:1,5 197:10,16,22 198:3,11 198:16,24 199:4,13 200:4 200:9,18 201:22 202:5,9 202:15 203:1,7,12,13,22 204:2,13,22 205:7,11 206:8,14 207:15 208:14 209:5,21,24 210:20 211:2 211:8,12,22 212:1 213:22 213:24 214:1,3,16,21 215:5,15 216:9,16,24 217:5,19 218:2,8,14,20 219:5,12,18,24 220:4,13 220:24 221:2,18,24 222:9 222:10,17,25 223:11,17 223:24 224:11,15,17,25 225:5,12,19 226:6,8,14 226:21 227:16,23 228:16 228:20 229:3,9,14,18,23 230:10,17 231:2,8 232:5 232:15,19,25 233:7,16 233:20 234:12,16,21 235:7,11,15,19 236:21 237:2,7,13 238:2,9,14 238:20,24 239:4,20,22 240:3,15 241:9,17 242:1 242:13 243:4,14 244:3,9 244:13,21 245:4,10,16 245:18,21 246:25 247:5 248:3,6,8,14,19,20,25 249:6,11,17 250:5,15,25</p>	<p>251:12,15,21 252:10,17 252:23 253:10,15 254:1 254:5,21,24 255:6,10,16 256:3,15,19 257:3,11,20 258:2,12,17,21 259:3,7 259:16,20,24 260:6,16 260:23 261:2,9,10,18,23 261:24 262:3,6,22,25 263:6,13,15,21 264:2,21 265:1,14,18,22,23,25 266:1,2,6,13,18 267:1,5 267:6,8,14,15,18 268:6 268:9,10,14 269:8,15,21 270:3,9,13,23 271:4,11 271:15,20,23,25 272:6 272:10,18,21 273:5,10 273:13,19,23 274:3,16 274:23 275:5,13,23 276:5 276:14,17,22 277:4,10 277:15,20,22,22,23,24 278:14,16,18,21,23,25 279:4,7,10,13,15,17 280:2,4,8,10,15,18,20 281:1,8,10,14,18,22,24 282:3,5,15,22,24 283:10 283:15,17,25 284:7,14 284:16,19,21 285:1,3,8 285:10,20,22,24 286:1 286:20,22 287:3,7,9,19 287:25 288:14,23,25 289:2,16,19,21,24,25 290:1,4,6,8,15 291:4,12 291:16,22 292:2,4,7,9 292:17,24 293:7 294:1,2 294:22 295:12,15,16 296:3,10,13,15,18,24 297:4,11,14,17,21,23 298:5,7,10,14,21,23 299:8,10,17,19,23,25 300:5,7,14,16,23 301:3 301:6,16,24 302:5,7,12 302:17,21 303:4,11,13 303:20,24 304:13,22 306:11,17 307:4,11,14 307:19,21 308:2,9,19,23 308:25 309:2,5,8,9,14 309:16,20,22,25 310:2,6 310:8,14,16 311:6,8,16 311:18 312:5,7,11,19,22 312:24 313:2,4,8,10,15 313:20,24 314:1,5,7,11 314:13,19 315:1,2,12,21 315:23 316:1,8,10,19,21 316:24 317:3,18,20 318:5 318:12,17,19 319:2,6,16 319:18 320:1,6,8,14,16 320:20 321:3,5,9,11,15 321:17,23 322:1,14,24 323:8 324:8,14,17,21,23 324:25 325:2,4,6,10,16 325:18,22 326:2,4,5,8 326:10,15,17,22,24 327:2 327:4,7,11,13,22 328:1 328:4,7,12,15,17,20,22 329:8,14,20 330:12,14 330:17,20,22 331:1,7,10 331:12,18,24 332:1,5,7 332:10,22,24 333:7,17 333:19,23 334:3,5,10,21 334:25 335:4,8,9,10,11 335:16,24 336:1,4,8,14 336:16,22,24 337:4,7,12 337:14,17,19,22 338:1,3</p>	<p>338:8,10,22,24 339:2,4 339:8,10,14,16,23,25 340:2,4,6,14,20,22 341:23,25 342:10,12 343:2,4,7,9,23 344:5,7,8 344:11,21 345:2,3,6,8 345:16,19,21,24 346:3,5 346:13,17 347:1,3,13,14 347:19,23 351:2,15,18 351:20,21,24 353:10,17 353:24 354:4,8,13,15,16 354:17,19,24 355:5,16 356:3,5,8,11,23 357:5,6 357:10,12,16,22,25 358:6 358:9,10,13,15,22 359:10 359:11,16,23,25 360:8 360:12,14,24 361:1,6,8 361:10,12,17,19,22,24 362:4,9,11,18,20,23,25 363:3,5,7,9,12,14,19,21 363:24 364:1,5,7,10,13 364:18,20,22 365:7,9,12 365:14,16,18,19 366:14 366:22 367:1,3,5,6,12 367:19 368:2,4,6,11,14 368:17,19,21,23,25 369:1 369:3,8,10,12,14,16,19 369:22,25 370:2,6,7,17 370:19 371:9,20 372:4,9 372:11,17,19,23 373:2,4 373:7,9,17,19,22 374:4 374:6,11,14,16,22,24 375:2,4,6,8,15,17,25 376:2,6,8,16,18 377:2,4 377:8,11,13,16,19,21 378:5,7,13,17 379:4,7 380:2,4,13,17 381:6,8 381:14,16 382:4,7,10,12 382:18,20,23 383:10,11 383:25 384:11,15,18,21 385:4,12,18 386:1,4,6,9 386:11,13,17,19,23 387:3 387:4,6,13,22 388:2,6,8 388:22,24 389:3,10,21 390:5,16,21 391:1,9,17 392:4,16,25 393:14 394:1 394:17 395:1,8,15,22 396:6,19,23 397:2,8,15 398:1,6,15,19 399:1,6 399:15,23 400:4,24 401:13,17,23 402:4,21 403:10,23 404:7,17,23 405:7,16,23 406:6,11,15 407:2 408:22 409:10,14 409:20 410:11,17,21,25 411:8,10,14,18,23 412:4 412:8,15,19,24 413:3,9 413:13 414:9,12,14,20 415:6,11,17,24 416:8,21 417:7,20,24 418:7,14,19 418:23 419:1,4,12 420:1 420:7,11,17,22 421:8,21 422:4,10,24 423:4,9,20 424:14,21,25 425:2,5,20 426:8,12,17,22 427:5,14 427:21,25 428:3,5,9,14 428:19 429:4,19 430:7 431:6,11,17,22 432:24 434:6,16 435:7,13,19 436:5,15,22 437:16 438:11,17,21 439:11,23 440:3,7,9,15,21 441:2,8 441:13,17,22 442:7,18</p>	<p>443:1,8,15,25 444:7,16 444:24 445:4,9,14,14,19 446:1,5,15,25 447:5,12 447:24 448:5,10,21 449:3 449:14,18,25 450:6,17 451:10 452:16,23 453:4 453:11,20,24 454:2,5,14 454:15 455:3,10,13,21 455:23 456:2,7,16,25 457:4,5,12,16</p> <p><b>Mullen</b> [1] 409:2</p> <p><b>multi-patient</b> [2] 282:7 282:17</p> <p><b>multiple</b> [4] 264:25 400:3 402:2 404:6</p> <p><b>Multitasking</b> [1] 265:9</p> <p><b>multitude</b> [6] 264:25 265:2,4 328:9 340:10,11</p> <p><b>MUN</b> [1] 152:16</p> <p><b>Muse</b> [4] 186:7 453:2,13 453:15</p> <p><b>must</b> [25] 7:9 9:2 14:21 31:22 97:9 109:24 111:2 111:10 119:23 135:2 164:16 167:3,5 200:1 212:12,15 225:13 232:7 234:17 236:8 256:4,20 257:4 291:19 340:1</p> <p><b>Myrtle</b> [3] 23:9 43:21,24</p> <p><b>mystified</b> [1] 399:4</p> <hr/> <p style="text-align: center;">-N-</p> <p><b>nail</b> [1] 48:21</p> <p><b>nailed</b> [1] 156:3</p> <p><b>name</b> [23] 34:15 37:21 62:18,23 63:15 64:1,21 244:23 258:7 268:1 269:11 271:25 277:24 301:8 343:11 358:7 366:7 366:17,23 367:10,15 384:12 407:11</p> <p><b>names</b> [8] 28:22 34:16 34:18,22 69:15 205:20 245:24 247:7</p> <p><b>Nancy</b> [19] 62:5 78:25 79:11,13,16 82:15 188:5 194:25 196:9 210:10,12 252:1 261:21 268:15 344:8 346:14 353:5 355:22 384:13</p> <p><b>Nash</b> [2] 97:25 102:16</p> <p><b>nation</b> [1] 106:12</p> <p><b>national</b> [1] 433:4</p> <p><b>nature</b> [5] 98:4 99:10 181:20 342:8 402:9</p> <p><b>necessarily</b> [7] 151:25 295:20 297:13 312:20 337:25 350:23 396:25</p> <p><b>necessary</b> [3] 344:16,18 344:19</p> <p><b>need</b> [55] 14:15 15:19 19:16 80:4 87:24 96:19 116:3,24 124:9,18 125:9 143:9 152:25,25 153:2 153:21 194:22 200:13 201:17 205:8 208:21 213:19 220:21 221:1,16</p>
--	---	--	---	--

<p>222:1,7,23 231:14,16,19 231:20,24 240:10 252:18 254:8,15,16,19,21 255:25 272:25 273:24 289:5 290:21 295:10 296:5 299:22 305:4 331:8 377:10 401:6 432:4 450:25 451:4 <b>needed</b> [10] 16:6 35:22 40:15 81:10 106:7 122:12 162:12 232:3 256:7 451:11 <b>needle</b> [2] 372:14,25 <b>needs</b> [3] 116:17 123:2 162:9 <b>negative</b> [57] 13:21,23 29:10,15 30:22 33:12 56:13 57:21 68:5 86:7 86:13,15 134:11,14,21 134:24 135:8,9 143:2,3 143:6 148:14 210:4 226:12 235:7 236:13 246:4 262:13 264:17 276:2 334:24 361:5,15 364:16 366:6 369:7,11 370:24 371:5 374:21 375:11 377:6 378:3,10 378:19 379:15 383:18 384:6,8,25 385:24,24 407:5 417:9,15 421:10 425:19 <b>negative/PR</b> [1] 364:15 <b>negatives</b> [6] 99:21 140:25 150:11 332:15 373:16 417:13 <b>network</b> [1] 432:10 <b>never</b> [36] 9:11 12:7 38:12 69:4 71:16,24 72:20,21,22 74:5 85:4,7 101:11 103:25,25 130:8 148:25 163:5,11,17 167:15 168:9,17,18 189:15 210:5 211:14 222:10 223:13 234:15 237:11 280:24 312:15 356:9 392:17 405:24 <b>new</b> [15] 6:23 58:1 93:10 117:7,8 121:13 298:1 317:22 318:20 321:20 325:19 342:4 354:5 402:7 402:17 <b>Newbury</b> [268] 1:15 2:5 277:15,20,22,23,25 278:16,21,25 279:7,13 279:17 280:4,10,18 281:1 281:10,18,24 282:5,22 283:10,17 284:7,16,21 285:3,10,22 286:1 287:3 287:9 288:14,25 289:16 289:21 290:4,8 291:4,16 292:2,7,17 293:7 294:1 294:2,22 295:12,15 296:10,15,24 297:11,17 297:23 298:7,14,23 299:10,19,25 300:7,16 301:3,16 302:5,12,21 303:11,20 304:13 306:11 307:4,14,21 308:9,23 309:2,8,16,22 310:2,8 310:16 311:8,18 312:7</p>	<p>312:19,24 313:4,10,20 314:1,7,13 315:1,21 316:1,10,21 317:3,20 318:12,19 319:6,18 320:6 320:14,20 321:5,11,17 322:1,24 324:8,17,23 325:2,6,16,22 326:4,10 326:17,24 327:4,11,22 328:4,12,17,22 330:12 330:17,22 331:7,12,24 332:5,10,24 333:17,23 334:5,21 335:4,10,24 336:4,14,22 337:4,12,17 337:22 338:3,10,24 339:4 339:10,16,25 340:4,14 340:22 341:25 343:4,23 344:7 345:2,8,19,24 346:5,14 347:23 351:18 351:24 354:8,15,24 355:16 356:5,11 357:5 357:12,22 358:6,13 359:10,23 360:8,14 361:1 361:8,12,19,24 362:9,20 362:25 363:5,9,14,21 364:1,7,13,20 365:9,14 365:18 366:22 367:3,12 368:2,6,14,19,23 369:10 369:14,19,25 370:6,19 371:20 372:9,17,23 373:4 373:9,19 374:4,11,16,24 375:4,8,17 376:2,8,18 377:4,11,16,21 378:7,17 379:7 380:4,17 381:8,16 382:7,12,20 383:10 384:11,18 385:4,18 386:4 386:9,13,19 387:3 <b>Newfoundland</b> [6] 17:17,21 42:21 431:16 458:8,11 <b>Newman</b> [4] 205:22 206:7 207:3,25 <b>news</b> [3] 293:19,20 355:15 <b>Newspaper</b> [1] 453:3 <b>next</b> [17] 102:20 143:24 201:16 207:15 263:19 345:14 348:20 349:13,17 350:3,11 353:12 406:14 430:12 435:25 439:14 454:22 <b>night</b> [2] 9:2 213:10 <b>nine</b> [11] 21:18,20 29:14 33:10 133:4 134:12 135:15 165:17 254:12 256:25 365:1 <b>NL</b> [3] 1:8,14,15 <b>NLCHI</b> [9] 252:19 253:1 253:8,22 359:13 360:9 381:22,25 416:11 <b>nobody</b> [6] 27:6 125:5 126:22 264:4 397:3,21 <b>non</b> [1] 56:2 <b>none</b> [1] 47:2 <b>nonetheless</b> [1] 144:21 <b>nor</b> [1] 263:24 <b>normally</b> [3] 26:10 111:8 277:15 <b>note</b> [54] 4:15,16,17 5:25 8:12,15 9:9 10:9,14 12:1</p>	<p>12:21 13:17 14:20 15:14 17:25 20:14 21:6,23 23:11 28:18 38:3,5,6,7 38:10 42:5 43:1,2,18 44:22 47:21 51:13 53:11 53:24 54:1,2,4,10,21 55:7 57:9 69:3 71:3 96:20,25 128:24 132:1 136:1 165:23 181:3 234:25 236:8 373:14 416:12 <b>noted</b> [3] 28:20 103:20 385:21 <b>notes</b> [21] 9:4,23 26:18 26:21 27:12 32:7,23 34:19,20 36:5 110:4,12 110:17,24 118:9 264:6 264:13 272:14,21 311:10 311:13 <b>nothing</b> [14] 9:19 13:9 20:23 43:11 179:8,8 214:21,25 282:19 323:18 323:18 354:5 401:20 424:18 <b>notice</b> [3] 248:6,11 441:18 <b>noticed</b> [1] 293:13 <b>notification</b> [3] 246:2 439:9 442:1 <b>notifications</b> [1] 194:23 <b>notified</b> [11] 14:14 188:18 189:1 190:14 191:7 236:13,15,18 245:13,23 384:9 <b>notify</b> [5] 246:16 250:20 406:21 407:1 441:20 <b>notifying</b> [1] 439:4 <b>notion</b> [1] 423:3 <b>nots</b> [1] 73:12 <b>notwithstanding</b> [1] 341:8 <b>November</b> [39] 9:18 36:4 62:15 65:15,15 70:17 84:5,7 95:3,4,9 96:8,17 97:15,22 106:17 106:18 108:24 109:24 110:19,24 111:25 112:3 114:14 115:5 117:13 121:18 127:19 153:14 154:21 165:18 257:15 263:24 264:6,6 268:21 270:15,22 271:3 <b>now</b> [129] 5:23 13:4 17:25 18:4 20:12 23:8 26:13 31:2,22 33:16 44:5 61:22 62:21 64:20 66:15,18 73:3,16,23 76:6,22 77:11 81:18 83:2,9 90:19,22 100:17,23 102:25 105:13 115:18 118:4 130:18 135:20 141:1,10 147:11 147:12 156:10,21 161:22 162:7 170:2 171:8 173:6 187:4 192:10 206:22 216:1 217:16 220:2 221:24 232:3 233:8 234:17 251:16,22 254:13 255:22 257:15 265:7,25 266:14,21 285:17 286:11</p>	<p>286:16 290:2 291:3 308:10,16,20 318:9 319:7 329:2 334:20 335:2 343:10 346:19 347:24 348:18 350:5,6 352:7 356:17 357:6 358:3,14 362:10,15 363:10 366:10 377:5 381:18,21 382:1 384:25 385:22 386:21,24 392:7 395:18 400:14 403:9 409:12 421:18 423:22 424:1 426:25 429:10 431:9 432:21 435:25 437:19 438:4 440:2,18 441:5 442:10 442:10 443:19 444:10 448:13 450:3 452:7 453:17,22 454:9 <b>nuances</b> [1] 46:5 <b>nuclear</b> [1] 375:13 <b>number</b> [73] 15:3 21:10 21:22 25:6,13,19 27:25 28:6 37:13 38:21 41:22 42:17 43:3 45:20 58:7 58:13 72:21 74:9 83:18 84:2,20 89:2 92:24 122:12 136:6 139:14 140:25 142:22 143:18 150:9 156:20 159:1 160:10,17,21 163:8 164:13,17,18,21 170:21 170:23 171:17 205:2 227:6,6 228:2 235:24 240:10 243:9 245:5 262:14 281:25 292:14 300:8 327:6 343:11 357:7 357:21,24 365:11 370:7 373:15 375:22 381:18 411:7,17 417:14 426:2 426:25 427:1 445:12 451:20 <b>numbers</b> [81] 16:23 18:8 18:8 22:13 42:4 61:9 84:8,13 96:19 97:5,12 97:16,17 127:24 129:20 129:23 132:2,12,22 140:8 141:18,18 142:13,14,18 144:13 146:19,20,22,23 147:6,9,11,12,14,15,17 147:23 148:23 149:4,5 149:10,13 151:16,20 152:8 153:3,6,12,15,20 157:24 161:9 162:25 164:5,12 165:16 166:1 170:11,14,19 171:10,13 172:20,25 173:2,3,4 177:19 184:4 187:4 202:11,12 204:12 210:16 253:19 292:19 294:11 375:19 420:25 421:5 <b>numerically</b> [1] 451:21 <b>numerous</b> [6] 145:20 155:3 252:1 331:5 354:23 450:8 <b>nurses</b> [1] 447:15 <b>Nursing</b> [1] 431:23</p>	<p>447:20 <b>obligated</b> [2] 201:13 281:12 <b>obligation</b> [2] 136:14 291:8 <b>observation</b> [5] 310:23 323:14 326:11 328:18 331:14 <b>observations</b> [1] 330:24 <b>observe</b> [1] 325:14 <b>observed</b> [1] 178:25 <b>obtain</b> [2] 60:3 312:10 <b>obtained</b> [5] 132:23 203:20 310:11 314:15 318:2 <b>obvious</b> [3] 165:13 397:12,17 <b>obviously</b> [13] 4:25 12:15 53:10 62:22 82:23 93:3 99:17 128:22 187:4 217:20 270:18 356:24 366:24 <b>occasional</b> [1] 236:6 <b>occur</b> [5] 238:13 331:5 333:3 340:21 395:19 <b>occurred</b> [5] 9:13 60:13 161:13 214:9 390:4 <b>occurrence</b> [56] 263:4 278:10,11 279:25 281:7 281:17 286:13 287:14,15 287:17 288:3,12,13 289:5 289:6 291:1,10 295:22 295:25 296:6,6,12 297:2 297:9 299:13,15,22 300:3 300:13,21 301:12,20 302:11,16 303:3,19 304:9 304:18,23 305:3,4,15 306:4,8,13,15,16 307:7 307:25 308:11,15 328:18 330:9 391:20,21 424:3 <b>occurrences</b> [12] 285:18 295:19 296:9,23 300:9 301:1,9 304:6 308:12 433:13,19 434:2 <b>October</b> [42] 1:4 36:4 61:22 64:4 66:21 69:6,9 70:9 74:9 78:17 83:19 234:9 235:2,8 237:21 240:19,21 241:4,7 242:24 242:25 243:10,12,12,22 249:21,22 252:6,13,18 254:6,12 268:16 396:20 407:1 409:2,2 432:23 440:6 442:12 458:5,12 <b>odd</b> [2] 9:9 209:16 <b>off</b> [30] 4:22 5:24 9:1 38:21 40:16 75:6 126:15 140:24 143:24 193:10,20 194:16 209:7 213:3 214:7 214:24 221:4 246:20 252:3 263:16 268:19 290:17 357:17 361:16 365:10 367:25 379:23 405:12 432:22 441:12 <b>offer</b> [2] 159:3 160:13 <b>offered</b> [8] 69:2 156:4 159:6 160:23 161:20 344:3 409:5,8</p>
---	--	--	--	---

-O-

Inquiry on Hormone Receptor Testing

<p><b>office</b> [10] 44:8 53:17 69:5,8 112:15 201:12,15 203:14 247:16,17 <b>officer</b> [1] 344:9 <b>offices</b> [2] 189:14 191:25 <b>official</b> [2] 355:2 410:15 <b>officials</b> [1] 55:5 <b>offing</b> [1] 390:20 <b>often</b> [3] 138:22,23 275:10 <b>old</b> [3] 325:15,20 402:23 <b>older</b> [3] 318:25 319:23 322:12 <b>omitted</b> [1] 134:22 <b>on-site</b> [1] 430:24 <b>once</b> [12] 20:24 125:19 185:10 217:24 306:23 308:3,3 403:5 432:1 434:5 449:24 452:14 <b>oncologist</b> [11] 57:7 59:18 60:3 148:23 251:10 349:3,4 352:20 355:22 408:18 409:16 <b>oncologists</b> [21] 26:15 27:2 56:16,25 77:9 116:20 210:9 247:23 310:5 345:9 348:11 349:23 352:8 353:12,17 355:3 356:12,17 379:24 396:9 439:19 <b>oncology</b> [2] 42:8 349:22 <b>one</b> [164] 6:2,3 9:7,10,13 9:17 11:18 12:24 24:22 29:9 30:10 34:15 36:2 36:15 52:13 55:10 61:1 63:23 64:18 77:8,9 78:7 78:11,12 79:5 91:23 108:22 109:23,24 110:2 111:9,10 115:1 129:25 130:1 137:19 141:5 142:21 151:15 152:22,22 156:7 173:23,24 174:5,6 179:20 183:24 184:13 188:3 195:13,15,16,23 199:24 205:10 207:21 208:9 215:16 232:11 233:1,13 240:14 241:1 241:23 245:19 250:16,20 251:4,14 257:22 260:8 262:2 265:5 267:6,24 270:4 282:13,18 288:8 292:10,11 293:14 294:25 297:5 305:14,17 306:12 306:22 315:16 316:3 319:8 323:15 324:10,12 324:15 325:20,21 327:24 328:3,6,11 329:21 332:18 332:20 333:9,20 335:6 336:9 337:6 339:20 343:22 345:22 355:18 356:25 360:19 362:5,14 362:22 365:19 371:3 373:11 374:18 378:2,18 379:2,12 380:21 383:20 385:23 387:16,20 388:6 389:24 391:20 394:9,12 394:22 402:16,17,18,22 403:3 406:18 411:6 414:4 414:22 426:7 432:14,25</p>	<p>433:1 434:18 435:24 436:1,6 445:16 447:20 452:19 455:7,24 456:10 456:21 457:3,13 <b>ones</b> [27] 25:3,7 28:8 29:18,25 61:3 86:1 147:3 147:4 148:20 162:12 189:6 195:1 233:21 241:14 253:18 334:12 353:21,22 354:3,5 357:17 376:21,22 385:14,16 435:22 <b>ongoing</b> [11] 50:1 51:19 51:24 52:2,6 102:20 106:1,10 115:25 296:20 399:10 <b>Ontario</b> [3] 69:16 436:25 437:1 <b>onto</b> [1] 11:9 <b>onus</b> [1] 330:1 <b>open</b> [3] 137:2 239:8 446:23 <b>operating</b> [4] 117:18 118:15,17 338:20 <b>opinion</b> [9] 17:24 28:5 126:2,4,6 167:21 203:4 212:6 445:18 <b>opinions</b> [3] 445:24 448:4,9 <b>OPIS</b> [2] 264:6,13 <b>opportunity</b> [1] 136:16 <b>opposed</b> [8] 81:22 141:5 335:14 378:16 380:15 396:10 434:3 440:25 <b>option</b> [2] 156:23 251:1 <b>options</b> [4] 249:24 250:1 250:14 251:8 <b>orally</b> [1] 415:10 <b>order</b> [4] 245:9 246:1,16 246:17 <b>ordered</b> [4] 65:24 66:3,8 201:11 <b>organization</b> [35] 10:3 76:9 115:22 116:17 282:8 282:11 283:12,20 284:9 306:10 327:10,20 330:1 337:9 338:14 339:5 427:19 428:25 429:13,17 430:6 431:5,15 432:23 433:7 434:5,18 435:2 439:2,8,22 442:25 444:13 445:2 448:19 <b>organization's</b> [2] 430:20,24 <b>organizational</b> [1] 342:9 <b>organizations</b> [3] 278:5 434:24 435:11 <b>organized</b> [1] 433:6 <b>organizing</b> [2] 95:2,5 <b>original</b> [18] 29:11 30:25 31:4,19 33:14,18 42:24 74:15,19 131:13 133:2 140:24 204:3 236:7 268:18 269:1 373:25 384:23 <b>originally</b> [8] 50:22</p>	<p>56:11 68:5 119:10 131:10 156:5 185:18 451:16 <b>originated</b> [4] 212:20 245:6 412:3 426:1 <b>originates</b> [2] 13:13 205:14 <b>Osborne</b> [3] 97:1,15 165:17 <b>Oscar</b> [3] 110:1 127:22 189:20 <b>otherwise</b> [11] 18:16 29:20 50:14 53:14 78:2 132:22 133:17 180:14 234:20 249:9 352:18 <b>ought</b> [1] 311:2 <b>ourselves</b> [1] 437:6 <b>outcome</b> [5] 78:8,11,13 334:14 404:13 <b>outcomes</b> [4] 136:15 430:1,4,22 <b>outset</b> [2] 361:15 377:7 <b>outside</b> [10] 51:22 161:12 163:4,9,13 166:4 168:17 206:2 288:2 409:6 <b>outstanding</b> [2] 103:22 108:5 <b>overall</b> [8] 145:22 174:18 184:4 264:19 359:17 389:19 429:7,25 <b>overload</b> [1] 400:18 <b>overlooked</b> [3] 343:21 343:22 399:20 <b>overly</b> [3] 99:17 102:2 170:16 <b>override</b> [1] 424:18 <b>oversee</b> [1] 123:19 <b>overseeing</b> [1] 121:25 <b>oversight</b> [1] 125:17 <b>owe</b> [1] 422:21 <b>own</b> [15] 27:12 60:1,25 173:5 206:2 239:11 253:3 272:21 273:14 274:14 304:19 308:11,16 311:10 365:2</p> <hr/> <p style="text-align: center;"><b>-P-</b></p> <p><b>P</b> [6] 29:4 211:24 259:23 286:2 317:4 365:20 <b>P-0056</b> [2] 279:9 403:19 <b>P-0057</b> [1] 76:8 <b>P-0067</b> [1] 315:2 <b>P-0073</b> [1] 437:19 <b>P-0092</b> [1] 442:10 <b>P-0103</b> [1] 362:11 <b>P-0125</b> [2] 37:17 55:2 <b>P-0183</b> [1] 136:5 <b>P-0192</b> [1] 17:13 <b>P-0287</b> [1] 393:17 <b>P-03</b> [1] 294:9 <b>P-0308</b> [1] 406:18 <b>P-0314</b> [1] 135:6 <b>P-0375</b> [2] 416:3 425:11 <b>P-0424</b> [1] 95:1</p>	<p><b>P-0665</b> [1] 453:9 <b>P-0704</b> [1] 205:1 <b>P-0720</b> [1] 370:13 <b>P-0783</b> [1] 341:3 <b>P-0820</b> [1] 13:11 <b>P-1179</b> [1] 61:18 <b>P-1188</b> [1] 74:7 <b>P-1263</b> [1] 231:12 <b>P-1268</b> [1] 238:17 <b>P-1273</b> [1] 240:6 <b>P-1427</b> [1] 249:20 <b>P-1447</b> [1] 8:2 <b>P-1957</b> [1] 243:24 <b>P-2107</b> [1] 97:21 <b>P-2108</b> [1] 115:4 <b>P-2116</b> [1] 200:21 <b>P-2618</b> [1] 28:12 <b>P-2633</b> [1] 265:5 <b>P-2634</b> [1] 265:5 <b>P-2642</b> [4] 360:18 365:21 379:1 383:14 <b>P-2662</b> [1] 96:16 <b>P-2692</b> [1] 251:24 <b>P-2875</b> [1] 257:14 <b>P-2976</b> [1] 452:20 <b>P-3044</b> [1] 67:24 <b>P-3047</b> [1] 68:23 <b>P-3048</b> [1] 70:8 <b>P-3053</b> [1] 134:6 <b>P-3055</b> [1] 432:20 <b>P-3056</b> [1] 129:17 <b>P-3058</b> [1] 193:15 <b>P-3059</b> [1] 197:13 <b>P-3060</b> [1] 203:11 <b>P-3061</b> [1] 109:19 <b>P-3064</b> [1] 209:19 <b>P-3065</b> [1] 224:2 <b>P-3076</b> [1] 250:24 <b>P-3077</b> [1] 252:16 <b>P-3078</b> [1] 254:4 <b>P-3369</b> [1] 428:3 <b>P-3445</b> [1] 260:14 <b>P-3462</b> [1] 267:11 <b>P-3468</b> [3] 3:2 295:14 412:1 <b>p.m</b> [3] 8:11 95:5 457:20 <b>pace</b> [1] 311:11 <b>page</b> [36] 6:2 20:8 21:23 23:4,7 37:17 51:6 93:17 112:12 132:5 234:1 254:8 258:5 260:19,20 262:2 286:17 315:6 346:9 347:24 349:17 350:3 362:16,22 365:21 393:17 403:20 404:2 406:18 416:3 417:18 418:2,4 425:23 429:22 430:12 <b>paged</b> [2] 113:12 202:9 <b>pages</b> [1] 286:18 <b>paid</b> [3] 10:16,18,22 <b>Pam</b> [6] 74:11 129:23</p>	<p>189:20 205:4 240:7 244:10 <b>panel</b> [91] 13:19,21 16:13 16:14 17:17,22,24 18:6 18:7 25:3,8,20 29:16 31:2,14 33:5,16 34:21 40:8 42:7,22 57:14 61:7 62:19 67:4 68:24 69:2 74:17,24 75:3,4,9 83:4 85:1,12 90:5 92:7,14 99:24,25 135:9 146:20 147:18 152:9 156:3 161:11,19 162:12 188:12 188:17,25 194:24 195:18 196:9 246:19,24 265:11 265:15,17 266:5,10 267:25 268:1,20,23 269:19 344:14,17 345:10 348:1,9 349:21 353:8 356:19 364:23 365:6,19 366:4 372:13 377:24 380:16 383:12,19,24 384:5 385:22 409:13,18 410:9,15,16 <b>panelled</b> [34] 32:16 36:3 56:3 65:12 68:25 69:9 188:10 192:22,23 247:1 247:4 266:23 267:24 268:9 269:23 347:8 351:17,23 352:5 353:21 353:23,24 354:7,12 368:1 371:17,18 377:17 379:9 379:15,20 381:5 383:17 386:15 <b>panelling</b> [13] 32:8 33:1 60:19 77:21 84:9 148:24 153:4 161:3,10,12 347:17 354:18 450:10 <b>paper</b> [7] 62:17 235:22 235:24 239:5 306:2,19 306:20 <b>papers</b> [1] 246:3 <b>paraffin</b> [1] 228:5 <b>paragraph</b> [15] 15:8 46:8,12 120:5,6 225:23 226:1 317:9 367:17 406:20 410:5 411:1 416:5 425:14 437:25 <b>paragraphs</b> [1] 417:4 <b>parameters</b> [4] 118:21 260:11 327:16 451:14 <b>paramount</b> [1] 119:22 <b>parking</b> [2] 146:17 202:8 <b>Parsons</b> [23] 72:15 113:12,19 129:24 191:23 209:25 244:4 335:9 344:8 344:11 345:3 346:14 347:3,13 351:2,21 353:6 353:24 354:4,16,17 355:23 384:14 <b>Parsons'</b> [1] 353:18 <b>part</b> [62] 4:18 5:7,10,16 6:7,24 26:9 43:22 47:24 53:7 54:1 78:9 155:25 165:1,6 166:17 167:2,21 169:16 170:6 171:3 173:7 176:19,21 199:19 200:10 203:8 205:25 212:3,25 213:2,5,15 215:8,11</p>
---	--	--	---	---

<p>218:22,23 227:4,22 235:4 236:11 290:21,24 301:13 301:25 302:4 303:5 304:12 315:14 320:9,19 327:19 360:1 372:21 373:23 391:19 414:5 429:10 441:23,25 448:25 457:9</p> <p><b>partial</b> [2] 217:14 262:12</p> <p><b>participants</b> [3] 446:24 447:10,11</p> <p><b>participate</b> [1] 22:20</p> <p><b>participated</b> [2] 435:17 449:13</p> <p><b>participating</b> [1] 179:14</p> <p><b>particular</b> [45] 53:25 61:2 66:16 67:3 87:1 181:6 220:8 225:8,11 236:13 260:10 261:8 272:13 275:2 278:5 281:13 285:16,23 287:12 291:19 298:1,2 301:18 304:17 309:19 317:9 327:24 335:14 339:1,13 341:10 342:17 344:2 373:11,15,21 375:1 383:21 385:8 412:2 421:6 435:12 444:13,14 455:23</p> <p><b>particularly</b> [3] 332:14 332:20 351:9</p> <p><b>particulars</b> [1] 227:9</p> <p><b>parts</b> [7] 125:25 301:2,4 304:11 315:19,20 402:8</p> <p><b>pass</b> [4] 64:8 104:14 291:9 394:18</p> <p><b>passage</b> [1] 307:8</p> <p><b>passing</b> [1] 416:12</p> <p><b>passionate</b> [1] 99:15</p> <p><b>past</b> [11] 34:10 91:18 124:17 186:4,11,24 187:3 209:14 236:5 288:11 403:12</p> <p><b>Pat</b> [5] 74:11 189:20 205:4 257:16 267:21</p> <p><b>patch</b> [1] 335:25</p> <p><b>pathologist</b> [2] 228:13 263:25</p> <p><b>pathologists</b> [7] 116:4 116:8 227:10 228:10 321:2,8,13</p> <p><b>pathology</b> [18] 42:9,16 62:15 67:2 89:24 228:21 231:4,17 232:24 262:9 262:10 264:1 285:19 286:11 289:18 315:19 372:16 452:3</p> <p><b>patient</b> [117] 32:21 33:3 33:4,5 34:15 36:2 66:16 72:13 75:11 78:7,11,12 79:1,10,11 80:7 81:23 92:1,7,8,15 136:25 188:20 195:8 199:19 201:3 203:18 210:1,2 222:4,16,22 223:10,13 226:5 234:4 235:23 237:22 239:14 241:6,10 241:11 242:21 247:4 258:6,8,16,24 259:9,12</p>	<p>260:10 261:8 262:11,19 262:24 264:7,16 266:11 266:12 267:9 274:19 275:2 302:23,25 303:23 306:7 329:21 340:15 343:5,10,24 344:9,9 345:13 348:13,14,21 349:1,12 350:6 351:9 354:11 355:20 360:10 361:14 362:5 364:15 365:22 366:5 367:16 371:25 373:11,15,21 375:10,14 378:9 383:15 383:16,21,22 385:9 389:13 402:3,18,25 404:14 405:13 406:4 422:22 424:16,17 430:8 430:13,18 431:2 435:6</p> <p><b>patient's</b> [9] 207:1 209:8 259:2 352:22 362:14 366:7,23 375:9 422:22</p> <p><b>patiently</b> [1] 356:1</p> <p><b>patients</b> [209] 5:19 13:20 13:22,25 14:2,5,11,14 14:17 29:2,18 30:20,21 32:5,15 33:10 36:18,23 42:17 46:16,21,23 48:25 51:21 57:2 58:2,14 59:7 60:1,6,12 71:14 72:18 72:20 75:17 76:12 78:12 81:10 89:2,4,6,9 90:10 90:15 91:1,15 129:15 131:20 153:1,5 156:21 161:17 186:8 188:4,17 189:1 190:3,14 191:6,7 201:6 203:16 205:20 210:14,19,25 211:6 213:18 220:21,25 221:6 221:7,16,22 222:1,3,7 222:23 223:23 234:6,8 234:14 235:3,9,25 236:12 236:14,17,23 237:1 239:8 239:10,17,18 240:11,14 240:19 241:4,14 243:16 245:7,8,13,15 246:8,19 247:1,7 249:14 250:4 251:10 252:9 253:17,18 254:9,14,16,20 255:13 256:1,11,25,25 257:2 264:18 266:17,22,25 270:4 275:3 281:25 282:10,14,18 283:24 284:12 285:6 317:6,13 324:16 331:15 332:13,17 333:4,25 334:1,2,24 335:7 339:19 340:25 342:23 344:4,11 345:4 346:18,21 350:8,13,17 351:5 352:2,5,6,11 354:21,23 355:9,14,24 356:14 359:19 360:3 361:2 362:2 363:17,22 364:4,8 367:15 369:5 381:5,18,18,21 382:1 386:15,21 392:23 398:12 398:25 400:9,12 404:21 405:2 423:16,19 439:4 440:22,24 441:19 442:1 442:16 443:6,9,18,23 444:11 453:16</p> <p><b>patients'</b> [1] 207:18</p> <p><b>PCI</b> [1] 264:9</p>	<p><b>peer</b> [5] 109:23 446:13 446:21 447:13 449:13</p> <p><b>pending</b> [2] 10:4 175:17</p> <p><b>people</b> [119] 21:15 22:22 25:1,1 26:18 28:6,20 34:12,23 35:4 45:21 57:1 64:23,25 67:15 70:13 71:4 74:10 75:14,16 78:22 81:8 90:9,25 92:24 92:25 94:8,11 98:21 103:6 114:17 121:13 124:19 126:4 135:15 136:6 137:15 141:23 142:5 145:5 147:25,25 150:9 152:9 156:9 157:2 159:3,6 160:14,23 161:5 163:2 164:13 171:14 173:2 190:19,20 205:3 206:25 215:8 225:4 236:9 242:23 243:1,2,8 246:3 247:2 249:23 250:9,18 251:25 254:13 255:1,18 256:6 257:10 272:23 275:12 297:25 300:2 307:24 308:4,7 310:23 311:2 312:9 313:11 323:9 324:18 326:13,21 329:23 330:6 331:20,21,22 334:18 335:19 351:22 353:15,19 359:3 370:10 383:13 401:4 407:7 427:1 427:11 432:1,15 433:6,7 446:13 447:21 448:2 449:12 456:21 457:12</p> <p><b>people's</b> [2] 178:13 312:14</p> <p><b>per</b> [1] 98:17</p> <p><b>perceive</b> [1] 335:11</p> <p><b>percept</b> [44] 62:14 143:12 151:20,21,23,24 186:4,5,8,11 187:3,9 228:12,15 326:12,19 328:19 329:2 330:24 333:3 335:12 348:17 370:11 371:13 379:23 409:4,4 416:6,16 417:9 417:10,11,12 418:18 419:3,23,25 422:2 425:16 426:16 451:21,22 453:8 453:16</p> <p><b>percentage</b> [4] 418:4,10 426:3,16</p> <p><b>perception</b> [1] 147:1</p> <p><b>perfectly</b> [2] 322:18 332:3</p> <p><b>perhaps</b> [60] 41:2 46:22 101:7 107:12 120:16 122:13,15,25 130:10 135:16 137:10 159:20 171:13 181:21 182:5,9 261:5 279:8 281:20 283:14 286:2,5 291:6 297:3 301:17 304:14 307:5 309:9 311:1,3,13 313:11 316:16 325:24,25 338:5 340:18 341:2 342:22 346:8 349:2 351:12 352:13 353:3 355:21,22 360:17 371:3 371:22 376:3 379:20</p>	<p>381:4 382:14 383:19 388:16 389:6 416:14 455:16,21 456:5</p> <p><b>period</b> [26] 9:5,20 11:13 24:20 25:5 31:4 33:18 58:20 74:16 86:8 99:22 100:8 101:14 125:6 240:14 242:22 245:22 323:20 330:23 342:3 367:25 385:14 406:2 428:12 451:6 457:14</p> <p><b>peripherally</b> [2] 198:25 436:6</p> <p><b>persistent</b> [1] 201:20</p> <p><b>person</b> [44] 26:19,20 63:17 67:17 68:25 74:13 75:14 80:11 81:2 87:4 87:13,14,14,24 97:17 107:10 114:9 122:6 123:10 148:22 185:16 192:21 194:22 222:15,21 288:9,11 290:2 301:19 335:21 371:14,16 374:1 377:14 384:4,5,6,7,9 386:2,8 400:17 406:24 436:12</p> <p><b>person's</b> [2] 206:22 384:12</p> <p><b>personal</b> [2] 178:13 201:9</p> <p><b>personally</b> [3] 91:16 208:5 215:1</p> <p><b>persons</b> [3] 55:25 57:12 342:15</p> <p><b>perspective</b> [21] 51:15 93:8 137:17 148:3,6 150:12 151:4,15 170:19 184:1 207:5,7 231:15 274:20 357:19 371:22 375:9 377:9 379:22 380:1 404:11</p> <p><b>pertaining</b> [1] 311:24</p> <p><b>perturbed</b> [1] 142:4</p> <p><b>perusal</b> [1] 244:2</p> <p><b>Peter</b> [3] 1:9 213:4,25</p> <p><b>Pg</b> [1] 3:2</p> <p><b>Pgs</b> [6] 2:3,4,5,6,7,8</p> <p><b>pharmacy</b> [4] 117:7 288:7,17 289:11</p> <p><b>phase</b> [2] 117:16 228:4</p> <p><b>philosophy</b> [2] 326:25 401:8</p> <p><b>phone</b> [19] 18:24 19:24 62:20 78:25 94:12 112:25 139:12 146:17 158:15 159:10,10,14,17 194:16 343:15 355:15 385:3 442:16,23</p> <p><b>phoned</b> [1] 219:2</p> <p><b>phonetic</b> [1] 327:15</p> <p><b>phoning</b> [3] 113:4,11 219:3</p> <p><b>physician</b> [35] 61:24,24 65:20,24 66:8 75:1,5 79:6,8 80:9,12 81:1,1,13 82:9,10 87:2,3 88:2,25 188:13,14 236:16 263:19</p>	<p>265:11 268:22 301:21 302:13,25 344:18,19 351:13 354:1,10 405:11</p> <p><b>physicians</b> [28] 80:18 80:24 81:7 86:25 88:6 88:16 89:8,14 90:4 117:9 188:16,18,24 189:11,13 189:22 190:7,13 191:5 191:12,15,25 236:19 237:11 245:5 405:1,6 447:15</p> <p><b>pick</b> [13] 64:1 106:13 197:8 234:22 238:6,10 239:23 242:3 243:18 263:20 287:22 316:20 420:23</p> <p><b>picked</b> [6] 63:15 141:4 263:11 264:4 371:17 377:23</p> <p><b>picking</b> [2] 441:11 455:19</p> <p><b>picks</b> [1] 288:10</p> <p><b>picture</b> [9] 141:22 142:24 144:17,18 146:24 148:17 217:18 320:13 360:16</p> <p><b>piece</b> [5] 52:4 190:15 262:4 306:20 444:10</p> <p><b>Pike</b> [2] 1:14 265:8</p> <p><b>Pilgrim</b> [27] 8:5,14 38:25 39:4,6 40:2,16,23 74:11 94:20 97:23 101:5 107:24 132:1 189:20 205:4 250:25 251:12 252:17 254:5 257:17 259:24 358:11,15 362:11 406:22 453:4</p> <p><b>Pilgrim's</b> [3] 267:15 368:25 453:12</p> <p><b>pitfalls</b> [2] 298:16 299:6</p> <p><b>place</b> [50] 76:14 86:20 93:13 103:25 104:18 105:2 106:6,8 108:5 114:15 116:15 117:6 118:20 119:16,21 120:2 120:12,17,22 121:2,5,11 121:18 122:18 124:12,21 124:25 133:24 160:13 239:16 259:6 264:20 278:4 279:21 281:4 285:12 289:7 298:12 323:3,5 327:17 329:17 330:5 338:15,18 352:4 354:18 356:15 358:20 403:4</p> <p><b>placed</b> [8] 29:11,12,16 33:21 34:5 133:2 415:21 416:4</p> <p><b>plan</b> [26] 30:24 33:13 56:8 58:1 59:5 60:23 61:11 78:16 106:9 121:7 171:4 177:4 194:24 196:8 237:1 250:3 256:9,12 293:20 343:18,19 441:14 441:24,25 452:12,17</p> <p><b>planned</b> [2] 78:21 437:5</p> <p><b>planning</b> [1] 98:12</p> <p><b>plans</b> [1] 293:22</p> <p><b>players</b> [1] 401:4</p>
--	--	--	---	---

<p><b>plus</b> [2] 96:2 426:6  <b>podium</b> [1] 388:15  <b>point</b> [90] 5:1 22:3 23:6  27:7 31:12,24 33:25 34:9  35:3 57:25 59:18,24  62:23 63:3 77:15 86:6  86:24 92:19 93:12 95:19  96:24 105:1 109:2,12  120:16 123:10 143:21  148:25 153:16 157:14  159:2 160:4 175:13,15  189:5,17 195:21 198:18  200:5 204:11,18 210:18  212:5 213:2,17 214:12  214:15 216:21 218:1,9  218:25 219:4,11 220:20  221:1,3,5,13,14,20  222:21 223:22 250:2  252:7 260:2 265:13  272:13 273:18 276:18  288:2 300:24 318:14  319:20 322:9 326:3  357:11,13 371:8,11  374:17 385:8 395:14  400:18 425:8 430:23  432:11 441:11 452:20  454:22 456:12  <b>pointed</b> [4] 18:11 241:23  352:23 419:13  <b>pointing</b> [1] 327:24  <b>points</b> [3] 115:21 185:3  232:4  <b>police</b> [1] 9:25  <b>polices</b> [1] 291:20  <b>policies</b> [27] 117:6,18  124:1 278:3,9,11,12  279:21,23 280:12,23  282:16 285:12,14 286:10  287:11,17 290:10,13  291:10 300:1 304:21  308:1 392:11 400:20  401:11 432:8  <b>policy</b> [45] 76:9,14,16  77:16 118:2 226:24 227:2  227:5,20,21,22,25 280:1  280:22 281:4,7,13 282:7  282:7,13,20 283:19,23  284:10,12,25 285:18,23  287:5,10,15 289:18  308:11 337:9,11 400:2  400:11,12 401:7,16 402:2  402:7,7 403:4,21  <b>poor</b> [2] 430:1,4  <b>popped</b> [1] 301:14  <b>portfolio</b> [3] 291:23  292:1,25  <b>portfolios</b> [1] 291:24  <b>portion</b> [5] 51:8 53:23  54:4,9 242:9  <b>portions</b> [1] 38:19  <b>portray</b> [1] 404:10  <b>posed</b> [1] 232:14  <b>posing</b> [1] 424:7  <b>position</b> [22] 47:16 87:11  88:24 89:8 167:6 168:2  176:22 184:5 198:17  266:2,13 273:14 318:3  334:23 342:24 343:6</p>	<p>346:23 396:16 412:10  439:7,19,20  <b>positive</b> [44] 13:23 29:10  29:15 31:2 33:16 49:1  83:5 84:23 85:3 86:16  134:16,20 135:9 157:10  226:5 229:2,11,20 230:1  236:10 246:4 260:1  262:13,21,22 276:2  348:17 357:20 359:12  360:4 364:15 371:1  375:11 417:8 418:4,10  421:11,11,19,20 422:7  425:19 426:3,6  <b>positives</b> [11] 83:12  85:25 99:21 100:7 101:15  143:18 260:5 381:24  417:14 421:12 451:25  <b>positivity</b> [18] 62:13  148:8,9 151:5 155:11  157:4,8 310:20 416:6,14  416:17 419:2 420:25  421:2,3 422:8,14 425:17  <b>possibility</b> [6] 80:24  155:8 291:14 352:17  353:1 454:21  <b>possible</b> [12] 70:13 71:4  201:19 207:20 235:1  249:25 283:22 285:7  347:9 348:13 397:2  454:25  <b>possibly</b> [6] 11:24 96:8  135:19 154:8 365:3  376:17  <b>post</b> [3] 156:6 247:16,17  <b>Post-it</b> [1] 243:25  <b>postpone</b> [1] 213:14  <b>potential</b> [17] 48:2,19  56:24 138:1 298:16 299:5  302:9 303:18 324:11  330:19 391:5,15,18 435:5  437:13 449:23 454:7  <b>potentially</b> [8] 28:7  46:18 47:5 129:12 130:23  133:1 134:13 397:25  <b>power</b> [1] 107:20  <b>PR</b> [33] 41:7 62:16 68:5  143:5 262:13,21 264:8  360:10 364:16 365:24  366:3 370:23 371:13  373:12 376:20,25 377:25  378:1,3,10,19,22 379:14  380:8 383:15 408:15  409:4 416:13 421:3,10  421:20 451:18,18  <b>practical</b> [1] 336:19  <b>practice</b> [8] 25:15 166:21  227:24 323:17,19 348:2  356:10 433:17  <b>practising</b> [1] 251:11  <b>pre</b> [1] 156:6  <b>pre-hearing</b> [1] 213:11  <b>precise</b> [1] 324:24  <b>predecessor</b> [1] 278:5  <b>Predham</b> [1216] 2:2 4:3  4:7,8,11,20 5:9,14,20 6:5  6:12,20 7:4,8,19,24 8:7  8:23 10:17,21 11:8,14</p>	<p>11:20 12:6,13,22 13:8  14:16,19 15:5,10,24 16:5  16:15,24 17:5,10,18  18:13,22 19:5,12,22 20:5  20:21 21:4,11,19 22:4,9  23:1,14,24 24:3,17,25  25:14 26:5,23 27:3,8,14  27:20 28:9,17,22,23  30:15 31:7,21 32:6,17  32:24 33:7 34:6,24 35:5  35:10,18,24 36:14,21  37:3,9,14,18,24 38:4,11  38:15 39:2,15 40:3,11  40:17,22 41:10,16,23  42:3,13 43:4,10,17 44:4  44:17,24 45:13,23 46:13  47:1,19,25 48:9,13 49:4  49:18,23 50:7,18 51:11  51:17 52:24 54:6,10,14  55:9,17,21 56:4,10,23  57:5,15,22 58:4,10,16  58:22 59:2,11,17,23 60:9  60:15,20 61:5,19 62:21  63:6,22 64:5,12 65:2,9  65:17,22 66:4,11,17,23  67:5,11,18 68:15,20  69:13 70:1,5,20 71:3,6  71:10,15,19,23 72:2,7  72:14,19 73:5,14,21 74:4  75:12 76:15 77:7,19 78:3  78:14 79:2,7,15 80:1,10  80:19 81:4,15,25 82:8  82:18,22 83:14,20,24  84:4,25 85:9,17,21 86:3  86:9,14,18,21 87:8,17  87:23 88:3,9,15 89:10  90:6,12,17 91:3,9,22  92:2,6,16,21 93:7,23  94:2,7,14,18,23 95:6,12  95:16,22 96:2,5,13 97:2  97:7,18 98:10 99:5,14  100:6,11,16,22 101:2,10  101:22 102:13,22 103:4  104:1,6,11,15,19 105:7  105:22 106:2,19 107:6  107:15 108:15,25 109:8  109:16 110:3,7,14,20  111:1,7,17,21 112:2,10  112:22 113:1,5,9,21  114:3,11,16 115:12,17  116:10,16 117:4,21 118:3  118:11,18 119:3,11,16  120:3,13,18,24 121:19  122:1,20 123:4,12,16,21  124:3,13 125:2,10 126:9  126:19,23 127:8 128:1,7  128:13,18 129:1,9 130:3  130:7,12,17 131:2,6,15  131:21 132:9,13,17 133:6  133:13,20 135:1,12,18  136:2 137:13 138:9,14  138:25 139:6,11 140:5  140:17,21 141:3,9,14  142:10,20 144:5,22 145:2  145:10,17 146:2,9,15  147:8,13,22 148:12,19  149:7,14,22 150:2,13,18  151:8,12 152:2,6,23  153:17 154:1,24 155:20  155:24 156:24 157:5,9  157:17 158:8,12,17,21  159:9,15,22 160:5,11,18  160:22 161:2,7,21 162:2</p>	<p>162:14,21 163:3,15,20  164:6,15,23 165:3,8,19  166:2,11,20,24 167:7,17  167:25 168:11,15,23  169:7,11,17,23 170:8,15  170:24 171:6,16,21 172:1  172:6,11,16,21 173:9,16  173:21 174:8,13,20 175:1  175:6,10,14,22 176:2,11  176:18,24 177:3,8,13,25  178:9,14,20 179:4,9,16  179:22 180:3,8,16,21  182:13,18 183:4,10,14  183:20 184:7,12 185:5  185:11,22 186:13,17  187:5,11,16,22 189:2,12  189:25 190:8,17,25 191:8  191:16,21 192:7,13,18  192:25 193:5,11,23 194:4  194:11,18 195:12,24  196:3,12,18,22 197:1,5  197:10,16,22 198:3,11  198:16,24 199:4,13 200:4  200:9,18 201:22 202:5  203:1,7,22 204:2,13,22  205:7,11 206:8,14 208:14  209:5 210:20 211:2,8,12  213:23 214:1,16 215:5  215:15 216:9,16,24 217:5  217:19 218:2,8,14,20  219:5,12,18,24 220:2,4  220:13,24 221:2,18,24  222:9,17,25 223:11,17  223:24 224:11,17,25  225:5,12,19 226:6,8,14  226:21 227:16,23 228:16  228:20 229:3,9,14,18,23  230:10,17 231:2,8 232:5  232:15,19,25 233:7,16  233:20 234:12,16,21  235:8,11,15,19 236:21  237:2,7,13 238:2,9,14  238:20,24 239:4,20,22  240:3,15 241:9,17 242:1  242:13 243:4,14 244:3,9  244:13,21 245:10,16  246:25 247:5 248:3,8,14  248:19,25 249:6,11,17  250:5,15 251:15,21  252:10,23 253:10,15  254:1,21,24 255:6,10,16  256:3,15,19 257:3,11,20  258:2,12,17,21 259:3,7  259:16,20 260:6,16,23  261:2,9,18 262:6,23,25  263:6,13,21 264:2,21  265:1,14,18,22 266:1,6  266:18 267:1,5,14,18  268:6,10,14 269:8,15,21  270:9,13,23 271:4,15,20  271:23,25 272:10,18  273:5,10,19 274:3,16,23  275:5,13,23 276:5,14,22  277:4,10,22,24 278:14  278:18,23 279:4,10,15  280:2,8,15,20 281:8,14  281:22 282:3,15,24  283:15,25 284:14,19  285:1,8,20,24 286:20,22  287:7,19 288:23 289:2  289:19,24 290:6,15  291:12,22 292:4,9,24  295:16 296:3,13,18 297:4</p>	<p>297:14,21 298:5,10,21  299:8,17,23 300:5,14,23  301:6,24 302:7,17 303:4  303:13,24 304:22 306:17  307:11,19 308:2,19,25  309:5,9,14,20,25 310:6  310:14 311:6,16 312:5  312:11,22 313:2,8,15,24  314:5,11,19 315:3,12,23  316:8,19,24 317:18 318:5  318:17 319:2,16 320:1,8  320:16 321:3,9,15,23  322:14 323:8 324:14,21  324:25 325:4,10,18 326:2  326:5,8,15,22 327:2,7  327:13 328:1,7,15,20  329:8,14,20 330:14,20  331:1,10,18 332:1,7,22  333:7,19 334:3,10,25  335:8,11,16 336:1,8,16  336:24 337:7,14,19 338:1  338:8,22 339:2,8,14,23  340:2,6,20 341:23 343:2  343:9 344:5,8,21 345:6  345:16,21 346:3,17 347:1  347:14,19 351:15,20  353:10 354:13,19 355:5  356:3,8,23 357:6,10,16  357:25 358:9,22 359:11  359:16,25 360:12,24  361:6,10,17,22 362:4,18  362:23 363:3,7,12,19,24  364:5,10,18,22 365:7,12  365:16,19 366:14 367:1  367:5,6,19 368:4,11,17  368:21 369:1,3,8,12,16  369:22 370:2,7,17 371:9  372:4,11,19 373:2,7,17  373:22 374:6,14,22 375:2  375:6,15,25 376:6,16  377:2,8,13,19 378:5,13  379:4 380:2,13 381:6,14  382:4,10,18,23 383:11  383:25 384:15,21 385:12  386:1,6,11,17,23 387:4  387:6,13,22 388:2,7,8  388:22,24 389:3,10,21  390:5,16,21 391:1,9,17  392:4,16,25 393:14 394:1  394:17 395:1,8,15,22  396:6,19,23 397:2,8,15  398:1,6,15,19 399:1,6  399:15,23 400:4,24  401:13,17,23 402:4,21  403:10,23 404:7,17,23  405:7,16,23 406:6,11,15  407:2 409:20 410:11,17  410:21,25 411:8,14,18  411:23 412:4,8,15,19,24  413:9,13 414:9,12,14,20  415:6,11,17,24 416:8,21  417:7,20,24 418:7,14,19  418:23 419:1,4,12 420:1  420:7,11,17,22 421:8,21  422:4,10,24 423:4,9,20  424:14,21,25 425:2,5,20  426:8,12,17,22 427:5,14  427:21,25 428:4,9,14,19  429:4,19 430:7 431:6,11  431:17,22 432:24 434:6  434:16 435:7,13,19 436:5  436:15,22 437:16 438:11  438:17,21 439:11,23</p>
---	--	--	--	---

<p>440:9,15,21 441:2,8,13 441:22 442:7,18 443:1,8 443:15,25 444:7,16,24 445:4,9,19 446:1,5,15 446:25 447:5,12,24 448:5 448:10,21 449:3,14,18 449:25 450:6,17 451:10 452:16,23 453:20,25 454:2,14,15 455:3,13 456:7,25 457:12,16 <b>Predham/Pam</b> [1] 244:24 <b>predicted</b> [1] 155:14 <b>predictive</b> [1] 155:9 <b>preface</b> [1] 190:1 <b>prefer</b> [3] 251:1 277:19 449:4 <b>preference</b> [3] 168:20 168:24 170:3 <b>prejudging</b> [1] 212:19 <b>preliminary</b> [4] 152:15 154:13 156:14 261:24 <b>premier</b> [3] 19:16 37:19 54:19 <b>premier's</b> [1] 53:17 <b>premier/cabinet</b> [1] 28:19 <b>premise</b> [1] 423:7 <b>premises</b> [1] 329:21 <b>preoccupied</b> [1] 319:14 <b>preparation</b> [1] 145:25 <b>prepare</b> [5] 38:5,7 186:6 416:23 419:17 <b>prepared</b> [12] 6:1,3 7:12 8:6,13 29:4 37:23 38:2,5 204:20 445:13 452:15 <b>preparing</b> [4] 96:25 97:6 207:17 441:19 <b>presence</b> [2] 395:20 401:12 <b>present</b> [10] 52:11 72:5 73:1 115:9 171:20 206:6 269:6 393:22 411:22 439:1 <b>presentation</b> [25] 95:2 95:6,8,13,15,21 96:1,6 96:10,12 97:10,10 98:1 98:6,22 101:19 108:11 114:18 115:22 119:25 148:1 184:18,20 341:19 341:19 <b>presentations</b> [1] 95:10 <b>presented</b> [2] 98:8,9 <b>press</b> [6] 172:5 340:19 387:10 388:4,7 400:18 <b>pressing</b> [1] 173:24 <b>pressure</b> [1] 333:6 <b>presumably</b> [3] 151:16 151:17 298:3 <b>presume</b> [1] 406:3 <b>presumed</b> [1] 371:18 <b>pretty</b> [3] 126:6 244:14 422:15 <b>prevent</b> [9] 19:10 49:8 206:24 298:13 327:21</p>	<p>389:8 428:24 431:2 435:1 <b>prevention</b> [2] 434:2,14 <b>previous</b> [8] 9:17 78:17 212:18 229:10,15 257:21 269:25 421:15 <b>previously</b> [1] 254:10 <b>primarily</b> [2] 266:12 318:15 <b>principle</b> [2] 446:20 447:8 <b>printed</b> [1] 4:23 <b>prints</b> [1] 4:22 <b>priority</b> [2] 239:13 422:25 <b>Pritchard</b> [3] 1:8 271:11 271:12 <b>Pritchett</b> [22] 1:16 2:4 271:22,23,24 272:1,12 272:20 273:7,12,21 274:12,18,25 275:7,15 275:25 276:7,16 277:1,6 277:12 <b>privacy</b> [6] 200:19 201:10,14 203:14 205:18 206:15 <b>privilege</b> [3] 181:8 182:3 183:1 <b>prize</b> [1] 422:18 <b>proactive</b> [5] 355:20 390:8 391:11 427:9,17 <b>problem</b> [45] 47:9 61:7 85:25 89:20 130:15 150:3 152:7 181:2,8 199:17 200:14 205:24 206:18 275:9 276:11,12 280:16 280:21 283:13,14 291:7 309:12 326:12,20 329:5 329:7,13 330:18 332:17 332:19 334:8 335:13,15 341:7,10,17,22 342:2,21 344:2 375:21,24 376:1,5 399:5 <b>problems</b> [26] 23:10 48:22 49:2 273:1,25 274:5 280:13 283:8 292:20 298:3,4,9 306:1 322:2 324:12 331:14,16 333:3,25 339:7,13,21 343:20 344:3 407:9 454:13 <b>procedure</b> [4] 136:17 151:5 327:14,15 <b>procedures</b> [10] 49:10 52:19 117:6,18 118:16 118:17 299:21 323:2 324:20 338:21 <b>proceed</b> [1] 213:17 <b>proceeds</b> [1] 22:22 <b>process</b> [66] 9:12 38:14 38:16 50:24 60:19 67:14 70:16 75:2 78:9 87:21 88:11,23 111:3 117:8 120:22 121:2,13,23 122:5 123:5 124:3 148:2 152:12 157:20 159:3 164:2 166:14 167:3,11 168:7 208:22 228:22 243:7 276:12 282:20 289:7,15</p>	<p>297:24 298:2,8 299:2,7 302:4 304:12 325:13 338:14,17 341:24 345:18 350:23 353:14 402:5 429:2 435:25 437:9 441:23 442:4 446:14,22 446:24 447:10 449:2,13 450:7,10 452:9 <b>processes</b> [16] 49:14 116:15 119:16,20 120:2 120:12,23 121:20 123:24 125:16 323:21 330:4 389:7,12 430:22 437:2 <b>processor</b> [1] 448:18 <b>produce</b> [2] 227:11 318:3 <b>produced</b> [1] 151:17 <b>professional</b> [1] 10:3 <b>professionals</b> [1] 42:8 <b>proffered</b> [1] 419:23 <b>proffering</b> [1] 416:16 <b>proficiency</b> [2] 315:18 316:6 <b>profile</b> [1] 202:1 <b>progesterone</b> [1] 70:12 <b>program</b> [28] 60:5 127:1 188:21 190:2 285:13,19 288:20 290:11,19,25 291:19 292:21 295:17 296:1,8,17 298:1 299:14 300:4 301:19 303:2 304:1 304:17 307:6 316:4 352:3 355:4 428:7 <b>programs</b> [4] 288:22 297:5 316:15 323:4 <b>progress</b> [4] 24:10 45:9 105:6 106:4 <b>progressed</b> [17] 29:17 29:21,23 30:9 33:20 34:3 34:8 56:17 57:8 79:18 106:5 163:23 185:7 266:7 296:22 392:9 403:17 <b>progresses</b> [2] 64:19 287:23 <b>progressing</b> [2] 108:7 204:14 <b>progression</b> [3] 25:4 320:11 358:4 <b>prohibited</b> [1] 444:14 <b>project</b> [1] 436:8 <b>projects</b> [1] 432:8 <b>promised</b> [2] 224:4 249:23 <b>promote</b> [2] 446:20,22 <b>promoting</b> [1] 446:12 <b>promotion</b> [1] 447:9 <b>promotional</b> [1] 432:21 <b>prompt</b> [1] 210:12 <b>prompted</b> [2] 102:11 367:14 <b>promptly</b> [2] 283:13,22 <b>prompts</b> [3] 305:18,22 307:2 <b>proof</b> [3] 322:19 323:2 324:2</p>	<p><b>properly</b> [3] 223:20 242:18 274:14 <b>proposal</b> [1] 208:19 <b>proposing</b> [1] 250:14 <b>proposition</b> [1] 300:22 <b>propositions</b> [1] 423:14 <b>protected</b> [2] 116:1 136:24 <b>protecting</b> [1] 449:12 <b>protections</b> [1] 446:9 <b>protocol</b> [1] 349:15 <b>protocols</b> [1] 324:20 <b>prove</b> [1] 322:16 <b>provide</b> [22] 14:6 28:21 34:17 38:19 44:16 49:16 52:8 110:2 136:15 149:6 201:15 211:5 244:8 245:23 268:4 286:14 289:17 306:14 320:5 358:18 392:11 431:1 <b>provided</b> [40] 15:1,4 18:9 21:10 32:14,15 40:14 41:4,14,21 43:3,9 47:17 132:12 133:12,14 144:21 172:15 182:12 232:9,18 233:6 238:19 252:21 253:8,8,9,25 270:21 291:19 360:19 363:11 364:25 370:13,16 419:18 428:4 432:19 436:19 446:9 <b>provider</b> [5] 137:1 422:21,23 423:22 424:1 <b>providers</b> [2] 423:24 424:5 <b>provides</b> [2] 42:19 434:13 <b>providing</b> [9] 7:22 38:21 40:7 45:20,20 70:18 271:1 416:23 434:11 <b>province</b> [5] 51:23 52:13 116:4 277:9 432:5 <b>provincial</b> [2] 116:7 431:14 <b>provisos</b> [1] 25:17 <b>PRs</b> [2] 370:25 422:7 <b>public</b> [18] 15:15 136:14 138:21 202:1 204:12,20 212:17 213:19 220:22 221:16 224:20 238:18 239:9 376:11 407:21 439:9 441:17 442:1 <b>publicly</b> [10] 115:23 137:16 165:25 166:1,18 173:4 180:14 183:9 407:15 453:19 <b>published</b> [1] 440:6 <b>pull</b> [3] 35:8,13 278:9 <b>purchased</b> [1] 306:23 <b>purpose</b> [11] 19:4 106:21 106:23 107:2 124:15 160:12 219:3 220:8 305:6 361:21 391:19 <b>purposes</b> [3] 304:20 361:13 376:9 <b>pursuing</b> [1] 340:17</p>	<p><b>push</b> [1] 456:3 <b>pushing</b> [1] 340:12 <b>put</b> [49] 9:16 15:13 18:2 24:19 25:23 30:2 31:23 39:4 46:7 56:15 58:1 63:4 65:13,14 82:21 97:17 105:2 106:8,11 120:22 121:10 124:11,20 145:14 216:18 235:22,24 239:16 269:18 270:15 298:12 323:25 327:10 330:1 338:15,17 346:22 347:17 368:10 384:12 392:5,7,7 397:23 399:10 403:3 422:22 423:16 432:22 <b>putting</b> [8] 18:7 60:16 106:6,10 166:12 280:21 356:19 393:7</p> <hr/> <p style="text-align: center;">-Q-</p> <p><b>Q.C</b> [770] 1:6,7,12,14 2:3 2:6 4:4,5,10 5:5,12,17 5:22 6:9,15,22 7:6,14,21 8:1 9 10:12,19 11:2,12 11:16 12:2,9,18 13:1,10 14:23 15:7,12 16:1,10 16:21 17:1,8,12 18:15 18:25 19:8,14 20:1,7,25 21:8,16,21 22:6,12 23:3 23:19 24:1,5,23 25:9,24 26:11,25 27:5,10,16 28:4 28:11 30:17 31:9 32:2 32:12,20 33:2,9 34:13 35:1,7,15,21 36:1,16,24 37:5,11,16 38:8,13,17 39:12,25 40:5,13,19 41:1 41:12,18,25 42:6,15 43:6 43:13,19 44:12,19 45:1 45:16 46:9,15 47:4,22 48:5,11,24 49:6,21 50:2 50:11 51:3 54:24 55:14 61:16 63:18 64:2,7,22 65:5,11,19 66:2,7,14,19 66:25 67:23 68:17,22 69:23 70:3,7 71:2,8,12 71:17,21,25 72:4,9,16 72:24 73:8 74:1,6 76:5 77:4,14,25 78:10,23 79:4 79:9,23 80:5,16,21 81:12 81:20 82:4,14,20,25 83:16,22 84:1,19 85:6 85:14,19,23 86:5,11 91:8 91:24 92:4,12,18,23 93:16,25 94:4,10,16,21 94:25 95:14,18,24 96:11 96:15 97:4,13,20 99:2,7 100:3,9,13,18,24 101:6 101:17 102:4,15 103:1 103:24 104:3,8,13,17,23 105:19,24 106:14 107:1 107:8 108:9,20 109:5,10 109:18 110:5,9,16,22 111:4,13,19,23 112:7,20 112:24 113:3,7,16,24 114:7,13 115:3,14,20 116:13 117:11,24 118:7 118:14,25 119:6,13 120:7 120:15,20 121:16,24 122:8,23 123:9,14,18 126:1,12,21 127:2,12,17</p>
---	--	--	--	--

<p>128:4,11,15,21 129:3,11 130:9,14,21 131:4,8,17 131:23 132:11,15,21 133:8,15,22 134:5 135:5 135:14,22 136:4 138:6 138:11,18 139:2,8 140:1 140:14,19,23 141:6,12 142:6,16 143:20 144:19 144:24 145:6,12,21 146:5 146:11 147:5,10,20 148:10,15 149:2,9,16,25 150:7,15,22,24 152:20 153:10,19 154:20 155:18 155:22 156:19 157:1,7 157:11,25 158:10,14,19 159:7,12,19,25 160:7,15 160:20,25 161:4,14,24 162:5,17,23 163:12,18 164:3,9,20,25 165:5,15 165:21 166:7,16,22 167:1 167:14,19 168:8,13,19 169:3,9,13,20,25 170:12 170:20 171:2,9,19,24 172:4,9,13,18,23 173:13 173:18 174:4,10,17,22 175:3,8,12,19,24 176:7 176:15,20 177:1,6,11,21 178:3,12,16,22 179:6,11 179:18,25 180:5,10,18 181:10 182:4,16,20 183:6 183:12,17,25 184:9,22 185:9,13 186:3,15,20 187:7,13,20 188:1 189:9 189:18 190:5,10,23 191:2 191:13 192:4,9,15,20 193:2,7,14,25 194:6,13 194:20 195:20 196:1,7 196:15,20,24 197:3,7,12 197:18,24 198:5,13,21 199:1,8 200:2,7,16,20 201:24 202:23 203:3,10 203:24 204:8,17,25 205:9 205:13 206:11 207:14 209:2,18,23 210:22 211:4 211:10,16,23 214:11 215:2,10 216:5,11,20 217:1,13,23 218:6,10,16 219:1,8,16,21 220:1,6 220:18 221:11,23 222:14 222:19 223:7,15,21 224:1 224:13,21 225:2,9,15,21 226:10,16,23 227:18 228:1,18,23 229:6,12,16 229:21,25 230:12,19 231:5,11 232:12,17,21 233:2,24 234:18,23 235:13,17,21 236:25 237:4,9,15 238:11,16,22 239:2,6,24 240:5,24 241:13,19 242:5,15 243:6 243:23 244:5,11,19 245:2 245:12 246:23 247:3,21 248:5,10,16,23 249:2,8 249:13,19 250:12,23 251:19,23 252:15 253:6 253:12,23 254:3 255:4,8 255:12,24 256:10,17,23 257:8,13,24 258:4,14,19 258:25 259:5,10,18,22 260:13,18,25 261:4,16 262:1,8 263:2,10,18,23 264:5,23 265:3,8,10,16 265:20,24 266:3,15,20</p>	<p>267:3,10,16,20 268:8,12 269:5,10,17,24 270:11 270:20,25 271:6,18 294:12,17,24 295:6 388:12,22,23 389:5,17 390:1,12,18,23 391:7,13 391:24 392:13,20 393:11 393:16 394:3,21 395:5 395:12,17 396:2,14,21 397:1,10,20 398:3,8,17 398:21 399:3,12,21,25 400:13 401:9,15,19,25 402:13 403:7,18,25 404:15,19,25 405:9,20 405:25 406:8,13,17 407:10,19,24 408:3,8 409:22 410:2,13,19,23 411:4,11,16,21,25 412:6 412:11,17,21 413:2,11 413:17,21,25 414:6,11 414:16,25 415:8,13,19 416:1,10,25 417:16,22 418:1,9,16,21,25 419:10 419:20 420:5,9,14,19 421:17 422:1,6,12,19 423:2,6,11 424:6,19 454:6 <b>Q.C./Jane</b> [1] 1:9 <b>QA</b> [2] 120:11 304:12 <b>QRM</b> [1] 74:21 <b>qualification</b> [1] 190:16 <b>qualified</b> [2] 71:9 72:22 <b>quality</b> [65] 42:9 81:5 106:8 116:14,25 117:3 119:14,20,25 121:1 122:6 122:24,25 123:6,7 124:18 126:14 127:5 202:19 239:13 252:8 273:14 286:24 288:19,22 290:2 290:22,24 292:12,20 297:19 298:24 305:14 307:18 316:14 320:21,25 321:14 323:1,4 326:7 327:1 330:9 342:9 384:10 385:5 388:25 389:2,7,11 389:23 390:25 391:3 424:10,12 430:15,17,20 431:25 436:12 446:14,21 447:14 449:1,2 <b>quantity</b> [1] 310:22 <b>quarterly</b> [1] 291:18 <b>questioned</b> [6] 29:7 167:15 348:23 349:6,24 350:4 <b>questioning</b> [3] 184:16 259:19 445:15 <b>questions</b> [53] 7:23 8:18 13:14,16,18,19 14:10 16:11 40:9 89:9 165:25 184:21 212:10 216:6,7 224:6 232:13 235:25 253:2,5 267:24 268:5 271:7,13,19 272:3 277:13 278:1 283:8 284:2 314:24 322:20,22 333:6 342:19 342:25 343:12,13 358:3 359:4,5,9 370:22 385:7 387:5 392:2 400:14 405:10 427:1 429:23 434:9 445:12 453:3</p>	<p><b>quick</b> [5] 221:20 234:10 234:25 258:10 416:2 <b>quickly</b> [11] 62:19 223:19 235:1 284:3 306:1 330:16 347:8,18 425:8 452:22 454:24 <b>quiet</b> [1] 143:23 <b>Quinn</b> [15] 197:15 198:2 198:23 199:9,11 200:17 201:20 202:4,10,20 204:1 208:12 370:13 378:25 381:19 <b>Quinn's</b> [3] 202:1 203:15 379:16 <b>quite</b> [11] 113:10 124:14 271:8 287:20 301:9 325:19 350:15 377:23 412:11,17,21 413:2,11 413:17,21,25 414:6,11 414:16,25 415:8,13,19 416:1,10,25 417:16,22 418:1,9,16,21,25 419:10 419:20 420:5,9,14,19 421:17 422:1,6,12,19 423:2,6,11 424:6,19 454:6 <b>Q.C./Jane</b> [1] 1:9 <b>QA</b> [2] 120:11 304:12 <b>QRM</b> [1] 74:21 <b>qualification</b> [1] 190:16 <b>qualified</b> [2] 71:9 72:22 <b>quality</b> [65] 42:9 81:5 106:8 116:14,25 117:3 119:14,20,25 121:1 122:6 122:24,25 123:6,7 124:18 126:14 127:5 202:19 239:13 252:8 273:14 286:24 288:19,22 290:2 290:22,24 292:12,20 297:19 298:24 305:14 307:18 316:14 320:21,25 321:14 323:1,4 326:7 327:1 330:9 342:9 384:10 385:5 388:25 389:2,7,11 389:23 390:25 391:3 424:10,12 430:15,17,20 431:25 436:12 446:14,21 447:14 449:1,2 <b>quantity</b> [1] 310:22 <b>quarterly</b> [1] 291:18 <b>questioned</b> [6] 29:7 167:15 348:23 349:6,24 350:4 <b>questioning</b> [3] 184:16 259:19 445:15 <b>questions</b> [53] 7:23 8:18 13:14,16,18,19 14:10 16:11 40:9 89:9 165:25 184:21 212:10 216:6,7 224:6 232:13 235:25 253:2,5 267:24 268:5 271:7,13,19 272:3 277:13 278:1 283:8 284:2 314:24 322:20,22 333:6 342:19 342:25 343:12,13 358:3 359:4,5,9 370:22 385:7 387:5 392:2 400:14 405:10 427:1 429:23 434:9 445:12 453:3</p>	<p><b>quick</b> [5] 221:20 234:10 234:25 258:10 416:2 <b>quickly</b> [11] 62:19 223:19 235:1 284:3 306:1 330:16 347:8,18 425:8 452:22 454:24 <b>quiet</b> [1] 143:23 <b>Quinn</b> [15] 197:15 198:2 198:23 199:9,11 200:17 201:20 202:4,10,20 204:1 208:12 370:13 378:25 381:19 <b>Quinn's</b> [3] 202:1 203:15 379:16 <b>quite</b> [11] 113:10 124:14 271:8 287:20 301:9 325:19 350:15 377:23 412:11,17,21 413:2,11 413:17,21,25 414:6,11 414:16,25 415:8,13,19 416:1,10,25 417:16,22 418:1,9,16,21,25 419:10 419:20 420:5,9,14,19 421:17 422:1,6,12,19 423:2,6,11 424:6,19 454:6 <b>Q.C./Jane</b> [1] 1:9 <b>QA</b> [2] 120:11 304:12 <b>QRM</b> [1] 74:21 <b>qualification</b> [1] 190:16 <b>qualified</b> [2] 71:9 72:22 <b>quality</b> [65] 42:9 81:5 106:8 116:14,25 117:3 119:14,20,25 121:1 122:6 122:24,25 123:6,7 124:18 126:14 127:5 202:19 239:13 252:8 273:14 286:24 288:19,22 290:2 290:22,24 292:12,20 297:19 298:24 305:14 307:18 316:14 320:21,25 321:14 323:1,4 326:7 327:1 330:9 342:9 384:10 385:5 388:25 389:2,7,11 389:23 390:25 391:3 424:10,12 430:15,17,20 431:25 436:12 446:14,21 447:14 449:1,2 <b>quantity</b> [1] 310:22 <b>quarterly</b> [1] 291:18 <b>questioned</b> [6] 29:7 167:15 348:23 349:6,24 350:4 <b>questioning</b> [3] 184:16 259:19 445:15 <b>questions</b> [53] 7:23 8:18 13:14,16,18,19 14:10 16:11 40:9 89:9 165:25 184:21 212:10 216:6,7 224:6 232:13 235:25 253:2,5 267:24 268:5 271:7,13,19 272:3 277:13 278:1 283:8 284:2 314:24 322:20,22 333:6 342:19 342:25 343:12,13 358:3 359:4,5,9 370:22 385:7 387:5 392:2 400:14 405:10 427:1 429:23 434:9 445:12 453:3</p>	<p><b>readily</b> [4] 298:24 299:15 300:12 307:24 <b>reading</b> [6] 46:20 128:2 190:11 316:22 394:22 406:23 <b>ready</b> [5] 127:7 128:22 146:7 209:22 435:25 <b>real</b> [3] 87:20 151:21 387:20 <b>realistic</b> [2] 322:9 323:5 <b>realize</b> [9] 33:6 38:22 143:21 145:4 245:20 271:8 305:12 312:16 393:21 <b>realized</b> [7] 9:11,22 142:8 145:7 198:19 270:18 407:6 <b>really</b> [59] 9:18 10:9 11:24 16:6 24:19 60:12 61:11 77:3 84:5,9,15 87:3 89:8 105:12 124:18 125:8 128:10 137:23 139:22 141:17,21 143:7 144:16,17 145:14 146:3 146:23 150:12 152:11 153:3 154:14,15 156:2 162:10 179:23 215:23 216:17,18 258:18 265:7 282:10,17 283:11 284:12 312:3 319:3 322:15 323:18,19 332:18 335:1 339:19 340:12 357:20 358:23 366:18 420:18 433:17 439:13 <b>reason</b> [18] 67:2 81:5 87:11 166:8 167:22 199:22 207:10 208:3,16 220:14 255:13,20 276:3 365:5 382:21 397:2,21 405:21 <b>reasonable</b> [2] 337:5 389:9 <b>reasoning</b> [1] 59:25 <b>reasons</b> [8] 19:9 49:7 51:8 165:13 236:8 255:19 307:15 457:13 <b>receipt</b> [2] 42:22 348:1 <b>receive</b> [10] 12:10,12 49:1 75:6 112:25 194:2 210:5 216:13 232:13 246:5 <b>received</b> [30] 13:16 29:19 29:23 42:1 49:11 52:15 52:17 53:1,14 54:11 57:20 69:7 78:25 80:8 87:5 108:23 128:17 129:16 151:16 188:16,24 189:22 198:8,10 236:3 238:23 315:3 348:9 367:16 408:25 <b>receiving</b> [4] 210:25 252:7,8 345:10 <b>recent</b> [3] 43:20 109:14 231:13 <b>receptor</b> [7] 1:2 20:17 23:11 24:8 41:13 45:8 458:4 <b>receptors</b> [1] 16:19</p>	<p><b>RECESS</b> [1] 293:24 <b>recognition</b> [1] 300:20 <b>recognize</b> [3] 300:2 305:3 419:21 <b>recognizes</b> [1] 301:20 <b>recollection</b> [9] 5:6 15:22 17:9 25:10 50:12 50:17 55:11 82:15 104:20 <b>recollections</b> [2] 38:23 181:12 <b>recommend</b> [2] 75:5 366:7 <b>recommendation</b> [19] 34:1 69:1 76:21 89:19 103:20 109:4 110:19 143:1 316:3,7,11 344:24 366:4 383:17,23 384:7 409:18 410:9,20 <b>recommendations</b> [45] 13:24 31:13 35:19 49:12 50:6,23 52:8,10 102:10 102:17,19 103:19 105:2 105:17 106:16 107:14 108:3,4,8,22 109:13,15 109:22 112:5,9,14 114:1 115:24 117:17,23 119:17 120:9 122:9 123:20 126:16 315:7,10 316:23 318:20,24 319:4 322:8 348:11 355:10 430:25 <b>recommended</b> [14] 14:8 29:16 78:18 117:19 156:10 205:19 345:11 348:4,5 349:8 350:7 352:7 356:20 409:13 <b>recommends</b> [1] 316:12 <b>reconcile</b> [2] 234:10 253:4 <b>reconstruct</b> [2] 35:3,9 <b>reconstructed</b> [1] 30:5 <b>record</b> [6] 34:22 63:2 66:22 199:19 206:22 349:19 <b>records</b> [2] 61:2 205:20 <b>recovery</b> [1] 330:16 <b>recriminations</b> [1] 390:20 <b>recurrence</b> [6] 19:10 31:6,19 262:16 264:13 408:23 <b>recurrences</b> [1] 37:7 <b>reduce</b> [1] 319:21 <b>reducing</b> [1] 430:10 <b>refer</b> [10] 5:15 129:5,6 199:11 227:12 228:6 264:14 277:17 282:13 287:14 <b>reference</b> [24] 17:23 18:12,18 23:7 43:23 45:3 130:10,24 131:10,11 132:24 164:11 175:16 185:17 186:4,5,7 214:6 227:19 259:12 279:19 341:3 416:13 418:17 <b>referenced</b> [6] 21:13 135:16 146:3 206:9</p>
---	---	---	---	---	--

-R-



<p>212:23 244:14  <b>references</b> [1] 35:4  <b>referencing</b> [1] 187:8  <b>referral</b> [3] 272:16                  273:24 316:13  <b>referred</b> [23] 18:5 23:21                  37:21 130:25 133:3,4                  199:9 228:10,13 233:15                  247:25 262:17 263:15                  275:4 279:1 285:15 286:8                  297:19 370:11 420:21                  425:11,13 426:2  <b>referring</b> [10] 34:14                  228:24 233:14 248:13                  252:22 272:24 274:21                  351:21 362:22 363:2  <b>refers</b> [8] 15:13 18:6 41:5                  41:7 136:7 180:6 229:7                  251:20  <b>reflect</b> [8] 84:9 146:21                  150:5 153:8 217:25 362:1                  420:25 421:2  <b>reflected</b> [3] 178:4                  365:20 370:15  <b>reflecting</b> [1] 311:14  <b>reflection</b> [1] 142:19  <b>refresh</b> [1] 326:1  <b>refuse</b> [4] 207:11 208:3                  208:11,16  <b>refusing</b> [1] 82:16  <b>refute</b> [1] 54:13  <b>regard</b> [1] 258:1  <b>regarding</b> [17] 4:15                  16:12 40:8,8 51:21 55:17                  58:1 86:19 89:4 116:2                  201:3 227:9 263:4 334:7                  346:14 392:2 393:4  <b>regardless</b> [1] 256:13  <b>region</b> [1] 236:14  <b>regional</b> [4] 1:10,17                  202:18 314:17  <b>regions</b> [1] 6:19  <b>registered</b> [1] 247:19  <b>Registrar</b> [7] 6:2 134:7                  241:1 243:24 294:8,20                  295:1  <b>registry</b> [1] 406:9  <b>regular</b> [4] 77:24 121:22                  291:18 345:14  <b>reiterating</b> [1] 240:21  <b>relate</b> [1] 305:9  <b>related</b> [6] 62:17 98:11                  337:8 383:20 428:6 434:1  <b>relates</b> [1] 316:5  <b>relating</b> [2] 316:7 383:13  <b>relation</b> [8] 231:13 422:3                  423:17 424:8 432:20                  444:10,15,22  <b>relations</b> [3] 235:24                  237:22 344:9  <b>relayed</b> [3] 349:12,17                  376:10  <b>relaying</b> [1] 92:15  <b>release</b> [7] 172:5 199:20</p>	<p>201:8 205:19,23 207:18                  303:18  <b>released</b> [14] 164:1,1,5                  166:15 167:11 168:6,6                  185:10 212:23 232:7                  288:2 302:8 303:6,21  <b>releases</b> [1] 240:18  <b>releasing</b> [3] 39:1 173:4                  207:13  <b>reliable</b> [1] 318:4  <b>reliance</b> [4] 145:15 321:1                  415:21 416:4  <b>relied</b> [1] 313:13  <b>reluctance</b> [3] 166:17                  184:2,4  <b>rely</b> [3] 222:24 321:20                  355:23  <b>relying</b> [1] 312:9  <b>remain</b> [3] 68:9 75:6                  399:4  <b>remember</b> [78] 9:3,16                  11:23,25 12:16,23,24                  16:6,16 20:24 23:16                  28:23 31:22 32:18,18                  53:23 54:15 64:19 66:18                  67:22 77:8 79:17 94:19                  94:20 112:11 113:22,23                  115:18 118:4 135:4,19                  135:20,21 139:19 141:4                  146:4,6 154:7 156:6                  158:23 159:17,24 160:3                  162:3 164:7,7 170:16,17                  170:25 171:8,17 172:22                  179:23,23 180:17 224:18                  234:17 238:25 239:1                  254:2 259:21 261:1                  263:14 315:15 367:10,20                  367:20 369:23 370:5                  382:5 384:1 399:7 415:7                  420:13,13,18 429:9                  453:22  <b>remembered</b> [2] 130:18                  313:5  <b>remind</b> [2] 174:1 175:16  <b>reminders</b> [1] 327:16  <b>reoccurrence</b> [1] 49:9  <b>repeat</b> [4] 262:20,20                  264:11 365:24  <b>repeated</b> [4] 23:12 47:12                  237:25 238:12  <b>repeatedly</b> [3] 175:9                  216:7 291:8  <b>replace</b> [1] 290:11  <b>replied</b> [5] 348:10 349:19                  350:11,17,25  <b>replies</b> [2] 237:17 349:4  <b>reply</b> [3] 14:9 234:10                  351:7  <b>report</b> [51] 52:7,14 62:15                  89:24 92:25 116:7 127:10                  136:18 227:12,12 228:14                  230:14,20,24 243:25                  244:8,15 263:3,4 264:1                  275:18,22 282:14 286:25                  288:1,2,10,12,13 289:5                  289:6 291:23 292:5,18                  296:5,6,7 297:3 299:22</p>	<p>305:5 315:6 341:2,5,12                  365:25 390:24 391:2,8                  391:10,12 448:14  <b>reportable</b> [1] 391:5  <b>reported</b> [5] 301:11                  305:11 366:2 426:5                  427:12  <b>reporter</b> [2] 201:5,10  <b>reporters</b> [3] 136:15                  174:11 179:20  <b>reporting</b> [23] 117:1                  264:11 274:1 278:11                  279:25 286:13 287:18                  290:13 291:25 304:24                  305:16,20 306:2,4,8,13                  307:25 308:15 330:9                  391:20,21 433:13,21  <b>reports</b> [34] 42:17 43:21                  49:11 50:5 52:16,17,22                  53:2,5,13 117:8 194:2,3                  194:8 201:4,11,15,18                  203:18 228:12,21 231:4                  262:9 272:15 291:18                  292:22 293:3 301:12                  333:24 342:11 445:13,16                  445:24 446:10  <b>represent</b> [1] 277:25  <b>representative</b> [1]                  293:1  <b>representatives</b> [1]                  237:22  <b>request</b> [26] 61:23                  195:11 197:14 198:6,8,9                  198:18 199:3 201:4                  203:15 204:3,5 206:17                  206:17 207:7,18 208:23                  209:17 262:20 264:11                  295:10 350:21 352:22                  359:17 419:19 453:1  <b>requested</b> [8] 36:8 56:9                  56:12 68:7 207:22 268:16                  295:5 394:7  <b>requesting</b> [2] 199:14                  204:1  <b>requests</b> [1] 392:10  <b>require</b> [6] 207:8,9 364:8                  372:6,7 373:5  <b>required</b> [12] 19:15                  47:13 83:23,25 86:1                  88:18 149:12 161:6,18                  246:5,15 405:11  <b>requirements</b> [1] 104:9  <b>requires</b> [4] 116:20                  282:25 374:8 428:23  <b>reread</b> [1] 374:1  <b>research</b> [15] 85:8                  152:16 155:5 205:25                  207:5,7,23 208:13,17                  209:4 403:15 449:23                  450:18 452:2,14  <b>researchers</b> [1] 206:5  <b>resent</b> [1] 96:22  <b>resident</b> [1] 430:9  <b>resigned</b> [1] 99:24  <b>resolution</b> [2] 284:6                  454:25  <b>resolve</b> [1] 329:1</p>	<p><b>resonated</b> [1] 331:4  <b>resources</b> [1] 338:19  <b>respect</b> [10] 55:19,25                  56:8 59:7 60:12 118:1                  192:6 245:7 249:10                  262:24  <b>respected</b> [2] 181:19,20  <b>respond</b> [10] 54:13 68:11                  207:17 212:16 226:2                  235:1 283:12,21 286:12                  296:2  <b>responded</b> [1] 345:1  <b>responding</b> [4] 198:6                  250:25 284:22 309:11  <b>responds</b> [1] 375:20  <b>response</b> [17] 54:15                  68:12 94:6 128:16,20                  195:13 198:23,23 202:11                  202:25 212:24 221:20                  330:18 346:13 376:5                  405:4,5  <b>responses</b> [1] 251:7  <b>responsibilities</b> [3]                  389:1 424:12,13  <b>responsibility</b> [4]                  107:12 126:24 127:6,11  <b>responsible</b> [13] 75:1,5                  82:9 87:13,13 107:21,22                  127:9 188:13 222:15,22                  405:11,14  <b>rest</b> [8] 120:4,6 154:16                  195:7 253:17 315:25                  333:16 457:19  <b>restarted</b> [1] 442:5  <b>restored</b> [1] 116:25  <b>result</b> [22] 23:9 41:13                  65:14 152:8 155:10                  158:24 210:13 257:25                  273:2,4 300:19 302:22                  338:18 339:11 351:6                  375:11 401:11 409:3                  425:19 430:3 444:21                  445:7  <b>results</b> [153] 13:20 15:17                  19:9 22:14 28:24 29:3                  29:19 36:8 41:6,20 42:1                  42:10,19,20 46:18 47:10                  49:8 50:20 51:9 55:19                  56:9,12,20 57:14 58:7                  59:6,7,15,20 61:8 62:16                  63:9 65:25 67:1 68:7,9                  68:13 69:11 70:14 74:15                  76:21 77:21 78:18 82:11                  83:4 129:16 131:20                  132:23 139:15 148:13                  149:13,19 150:10 161:10                  164:14 174:19 186:18                  189:4 192:24 199:14,18                  201:6,7,7,9,14 203:16                  204:3,4 207:19 209:13                  210:6,17 221:21 236:11                  236:14,17 239:19 243:1                  248:1 249:25 250:16,21                  252:3,24 255:23 263:9                  263:17 264:9,14 268:20                  269:2,4 270:7,22 301:2                  301:10,22 302:14 303:6                  317:11,16,22 318:4,11                  319:23 320:5 321:22</p>	<p>332:15 334:18,19,20                  344:12,13 346:22 350:6                  350:24 351:22 352:5,15                  352:19 353:4,7,20 354:6                  356:7,16 357:2 359:8,12                  362:1 371:19 372:1,16                  380:16,20 384:20,23,25                  404:22 407:5 409:19                  419:7,8 439:3 440:13                  441:1 448:13 449:24                  450:12 451:5,9,15  <b>resume</b> [1] 126:17  <b>resumed</b> [2] 112:1                  126:13  <b>RESUMES</b> [2] 2:2 4:3  <b>resuming</b> [1] 122:19  <b>retention</b> [2] 226:25                  227:3  <b>retest</b> [16] 28:24 31:5                  33:19 55:19 65:13,24                  66:3,8 83:3 188:7 201:7                  234:7,8 307:9,15 344:13  <b>retested</b> [49] 15:9 22:18                  36:6,9 43:7 46:24 49:16                  51:22 62:6 63:1,13,20                  64:10,15,16 65:8,10,12                  68:5 83:13 129:5 140:11                  141:8 149:19,20 154:17                  155:15 171:5 186:9 188:9                  204:4 235:7 236:4 239:18                  254:10 255:23 256:12                  257:23 261:21 264:17,19                  359:19 360:3 382:2 383:3                  440:22,25 441:21 453:8  <b>retesting</b> [38] 22:16                  24:12 29:14 30:11,24                  33:14 45:11 56:17 62:7                  62:11 67:9 70:12 160:13                  235:4 236:11 237:24                  238:5 241:6 261:14                  264:15,17,19 310:17                  317:12 332:15 350:16                  352:3 356:15 366:3 371:1                  372:1 373:13 378:2,4,11                  380:22 383:2 452:14  <b>retests</b> [1] 242:24  <b>rethink</b> [1] 320:17  <b>retired</b> [1] 69:20  <b>retrieval</b> [1] 228:6  <b>retro</b> [41] 74:25 76:2                  83:10,18 84:2,17 129:14                  147:2,3 150:19,20 357:7                  357:8,14,18 360:16,22                  361:20 362:1,13 363:6                  364:3,17 365:4 366:12                  366:19 368:10,15 370:8                  370:15,23 371:8 374:2                  375:1,3 376:14,20 381:1                  381:10,12 382:14  <b>retrospect</b> [1] 339:17  <b>retrospectively</b> [1]                  299:5  <b>return</b> [3] 116:18 237:18                  406:1  <b>returned</b> [5] 42:18                  405:14 409:3 440:14                  441:1  <b>Returning</b> [1] 116:19</p>
---	---	---	---	--

<p><b>review</b> [73] 14:12,18 15:14,16 27:12 36:3 46:10 49:10 51:19,23 52:2,6,18 54:7 62:20 70:11,16 74:23 91:10 95:7 108:2 111:16 115:24 117:12 119:18 137:1 178:25,25 194:24 195:5 196:9,10 201:12 203:15 208:20 209:3 231:17 232:24 239:10 255:3 260:1,4 261:24 278:11 281:7 289:8 290:22 320:21 322:3 325:8 342:11 344:17,18 381:11 385:21 386:24 399:17 400:19 401:10,12 405:18 407:14 437:2 445:13 446:14,21 447:13,14 448:13,17 449:1,2,13</p> <p><b>reviewed</b> [26] 31:2 33:17 37:25 42:10,21 46:18,24 46:25 47:3 49:12 53:11 57:13 98:1 108:3 119:24 132:23 171:25 188:20 228:21 230:16 262:5 313:17 355:7 381:10 384:24 410:6</p> <p><b>reviewer</b> [1] 449:7</p> <p><b>reviewers</b> [5] 51:25 193:19 447:22 448:3,8</p> <p><b>reviewers'</b> [2] 102:17 116:7</p> <p><b>reviewing</b> [4] 47:15 52:19 343:17 344:15</p> <p><b>reviews</b> [9] 14:13 17:3,4 49:24 50:4 98:18 102:9 109:23 205:25</p> <p><b>revised</b> [2] 5:8 131:11</p> <p><b>revisions</b> [1] 14:25</p> <p><b>revisit</b> [1] 83:8</p> <p><b>rewards</b> [1] 408:20</p> <p><b>reworded</b> [1] 6:8</p> <p><b>RHAs</b> [2] 414:18,24</p> <p><b>Richard</b> [3] 205:22 207:25 208:2</p> <p><b>Rick</b> [2] 205:4,14</p> <p><b>Rick's</b> [1] 208:6</p> <p><b>right</b> [82] 1:8 6:6 11:13 31:22 43:20 46:1 61:15 64:6,20 66:18 73:16,22 80:3 84:15 91:14,16 96:23 100:17 113:11 118:4 125:20 131:3 138:23 141:10 152:3 161:22 203:6 207:2 208:17 229:22 230:2 233:8 243:7 251:16,22 254:13 279:11 290:5 291:3,17 292:3 293:10 298:22 303:12 308:20 315:22 329:15 337:5 343:13 347:22 350:3 351:19 361:7 374:5 377:12,17 379:8 380:18 381:20 388:21 389:2 405:8 411:5 412:14 413:15 415:5 416:20 424:1 425:8,9 427:24</p>	<p>429:10,22 433:9 435:4 436:10 440:1 442:10 448:20 453:22 454:9 456:14</p> <p><b>rightly</b> [2] 263:14 378:14</p> <p><b>rigorous</b> [1] 207:24</p> <p><b>risk</b> [45] 14:1 107:19 116:14 119:14,25 122:16 122:24 127:4 163:22 273:15 388:25 389:2 390:2,7,8,13,13 391:8 391:10,14 392:2 424:10 424:13,15 427:2,4,9 429:17 430:1,4,5,14,20 431:4,15 432:3,5,9,13 433:4 434:3,17,20,25 436:11</p> <p><b>risks</b> [3] 408:20 428:25 430:22</p> <p><b>RMSAM</b> [1] 434:19</p> <p><b>road</b> [5] 109:20 182:24 201:13 349:10,11</p> <p><b>Robert</b> [1] 234:3</p> <p><b>robust</b> [1] 433:3</p> <p><b>role</b> [15] 16:12,13 17:17 17:22 95:11 98:8 115:15 116:25 117:3 344:8 427:2 427:13 430:6 431:4 436:11</p> <p><b>roles</b> [1] 322:25</p> <p><b>Rolf</b> [1] 1:8</p> <p><b>roof</b> [2] 212:5 213:1</p> <p><b>room</b> [3] 293:12 324:24 387:9</p> <p><b>root</b> [2] 341:7 432:16</p> <p><b>Rosalind</b> [1] 407:11</p> <p><b>roundabout</b> [1] 193:21</p> <p><b>rounds</b> [1] 349:22</p> <p><b>route</b> [7] 65:4 76:3 77:24 78:4,20,21 395:11</p> <p><b>routine</b> [2] 295:21 357:4</p> <p><b>row</b> [2] 426:4,5</p> <p><b>rule</b> [2] 326:6,18</p> <p><b>Rumboldt</b> [4] 412:3,18 419:18 426:1</p> <p><b>run</b> [10] 226:1,3,13 227:6 227:7,10,13 231:23 233:3 393:8</p> <p><b>running</b> [1] 118:16</p> <p><b>rush</b> [1] 265:7</p>	<p><b>Sandra</b> [3] 1:7 2:3 4:3</p> <p><b>sat</b> [2] 82:10 139:23</p> <p><b>satisfaction</b> [3] 389:14 389:18,22</p> <p><b>satisfactory</b> [3] 126:17 200:17 405:5</p> <p><b>satisfied</b> [3] 185:1 200:12 203:17</p> <p><b>Saturday</b> [1] 272:6</p> <p><b>Saturday's</b> [1] 272:5</p> <p><b>saw</b> [12] 23:20 92:10 109:3 118:19 148:23 205:23 239:5 244:23 331:3 356:25 366:17 420:3</p> <p><b>says</b> [31] 4:16 13:16 19:15 20:10 29:24 30:2 50:13 51:9 119:14 160:9 178:5 188:24 201:4 210:10 212:8 221:12 228:3 230:3 239:7 242:9 244:1 276:1,3 282:13 410:6 421:9 425:15 426:5 428:22 430:16 453:15</p> <p><b>scan</b> [1] 320:11</p> <p><b>scenario</b> [1] 283:2</p> <p><b>scenarios</b> [1] 207:21</p> <p><b>schedule</b> [1] 293:16</p> <p><b>scheduled</b> [4] 236:4 293:14 385:21 394:4</p> <p><b>scheme</b> [1] 290:14</p> <p><b>Sciences</b> [3] 44:7 202:7 209:15</p> <p><b>scientific</b> [2] 151:22,23</p> <p><b>scrap</b> [2] 62:17 144:3</p> <p><b>screening</b> [3] 248:1,13 249:16</p> <p><b>script</b> [3] 254:17,22 255:9</p> <p><b>scroll</b> [5] 219:14 286:19 362:21,24 364:22</p> <p><b>scrub</b> [3] 127:21,25 135:17</p> <p><b>scrubbing</b> [1] 130:10</p> <p><b>scrutiny</b> [2] 208:25 304:10</p> <p><b>search</b> [1] 306:25</p> <p><b>searching</b> [1] 199:6</p> <p><b>seated</b> [3] 4:2 211:22 294:1</p> <p><b>second</b> [15] 20:20 26:9 36:7 174:6 362:16 366:1 367:9 378:9 379:11 394:11 410:5 411:1 417:18 425:23 426:7</p> <p><b>Secondly</b> [1] 136:22</p> <p><b>secretariat</b> [2] 28:19 38:2</p> <p><b>section</b> [5] 13:24 19:1 131:9 228:5 429:16</p> <p><b>see</b> [97] 6:17 7:2 8:19 9:4 10:8 11:21 14:24 18:3 19:1 20:12 21:6 23:5 27:12 38:9 51:7 61:6 62:4 68:25 80:25 85:24</p>	<p>93:1,5 95:25 103:10 104:10 105:1,13,17 109:6 118:5,17 124:15 125:11 129:4,20 130:3,24 131:9 131:10,18 134:8,19 135:7 136:8 145:22 147:1 196:5 200:10 212:20 217:17 224:7 225:10,17 228:3 239:20 248:7 252:13 262:3 274:20 278:8 293:2 296:8 299:5 305:5 306:7 308:6 344:15 366:11 379:11 380:20 386:2 393:23 394:8 400:21 403:15 406:19 410:5 414:7 416:7 418:10,12 418:15,22 420:20 422:13 423:18,21 424:11 425:2 425:3,17 426:5,11 431:9 442:13 456:12 457:19</p> <p><b>seeing</b> [8] 10:10 28:7 126:7 141:15,16 186:19 239:3 388:3</p> <p><b>seek</b> [2] 396:3 397:13</p> <p><b>seeking</b> [2] 219:9 220:9</p> <p><b>seem</b> [9] 84:22 133:7 207:1 208:16,24 389:7,9 415:4 426:20</p> <p><b>sees</b> [1] 307:7</p> <p><b>select</b> [1] 317:12</p> <p><b>self</b> [8] 65:1,6 430:24 434:21,25 435:11,17 436:13</p> <p><b>self-assessment</b> [1] 429:10</p> <p><b>semi</b> [1] 437:3</p> <p><b>semi-critical</b> [1] 436:25</p> <p><b>send</b> [12] 8:4,12 12:11 54:21 75:15 87:24 201:14 245:25 247:10 251:25 268:19 399:13</p> <p><b>sending</b> [17] 53:21 77:24 80:22,23 81:21 82:6 112:9 131:25 190:19,20 212:21 274:1 275:12 398:11,11 442:16 443:5</p> <p><b>sends</b> [1] 362:11</p> <p><b>sense</b> [8] 25:7 46:2 67:16 137:4 168:1 260:21 316:16 358:2</p> <p><b>sensitive</b> [5] 215:21 312:1 318:10 319:11 322:7</p> <p><b>sent</b> [44] 5:19,25 8:20 12:14 28:24 41:21 54:6 68:6 70:23 76:2 79:5 80:11,11 82:3 87:2 92:7 92:24 94:5 114:2 137:8 137:15 156:12,14 158:1 198:1 201:11 215:19,19 215:23 220:15 237:24 238:4 245:7,9 248:12 254:11 267:25 268:2,3 317:7 406:22 412:22 414:22 453:4</p> <p><b>sentence</b> [4] 128:2,3 417:4 425:15</p> <p><b>sentences</b> [2] 5:11</p>	<p>311:13</p> <p><b>sentinel</b> [3] 279:25 280:17 284:24</p> <p><b>separately</b> [1] 210:9</p> <p><b>September</b> [20] 67:25 68:7 75:3 188:15,23 189:10,21 213:15 245:4 254:12 270:15 341:17 346:9 358:16,17 408:24 413:7 440:1,2 455:11</p> <p><b>series</b> [2] 13:16 364:23</p> <p><b>serious</b> [4] 11:6 158:5 334:14 436:24</p> <p><b>seriously</b> [1] 276:24</p> <p><b>seriousness</b> [1] 291:6</p> <p><b>served</b> [3] 43:25 44:10 44:13</p> <p><b>serves</b> [1] 7:11</p> <p><b>services</b> [3] 42:9 222:11 428:8</p> <p><b>session</b> [3] 136:11 338:16 341:11</p> <p><b>set</b> [7] 25:20 139:9 154:2 231:16 264:18 302:14 352:20</p> <p><b>setting</b> [1] 123:5</p> <p><b>settle</b> [1] 456:15</p> <p><b>seven</b> [4] 379:18 385:20 385:25 416:5</p> <p><b>seven-year</b> [1] 425:16</p> <p><b>seven/eight</b> [1] 155:12</p> <p><b>several</b> [15] 94:8,11 208:6 225:6 311:9 315:6 324:15 340:7 341:9 343:25 371:2 378:8 385:19 435:20,21</p> <p><b>share</b> [6] 116:3 144:2 145:8 195:22 344:4 432:7</p> <p><b>shared</b> [8] 20:4 26:3 53:8 53:20 138:5 179:12 252:25 437:7</p> <p><b>sharing</b> [1] 137:5</p> <p><b>Sharon</b> [3] 74:12 194:14 362:12</p> <p><b>shoot</b> [1] 143:24</p> <p><b>short</b> [6] 234:10 241:5 367:25 417:1,4 440:14</p> <p><b>shorter</b> [1] 361:13</p> <p><b>shortly</b> [5] 106:25 145:24 206:17 319:7 403:5</p> <p><b>shot</b> [1] 417:19</p> <p><b>show</b> [12] 106:17 172:19 228:8 229:7 230:4,21 362:15 370:20 371:3 376:19 377:22 453:9</p> <p><b>showed</b> [7] 4:12 62:13 132:4 262:21 288:1 372:25 425:24</p> <p><b>showing</b> [2] 201:20 376:21</p> <p><b>shown</b> [5] 188:9 341:4 360:15 437:19 453:6</p> <p><b>sic</b> [2] 28:23 187:14</p> <p><b>Siddiqui</b> [3] 348:25 352:9 355:18</p>
---	--	---	---	--

**-S-**

**safe** [4] 309:9 424:15  
430:18 433:16

**safeguards** [1] 239:16

**safety** [11] 123:7 274:19  
306:7 329:22 389:18,24  
403:1 424:16 430:14,18  
431:2

**sample** [5] 273:3 274:1  
275:18 276:8 409:1

**samples** [8] 49:15 51:21  
226:5 239:17 275:12  
373:11 378:8 441:20

<p><b>Siddiqui's</b> [1] 346:1  <b>side</b> [18] 84:11 143:10  153:6 154:5 364:11 370:9  384:4 390:7,8 391:11,12  427:9,10,13,17 430:9  434:14,18  <b>sided</b> [1] 274:7  <b>sides</b> [1] 77:2  <b>sign</b> [5] 40:16 185:16  227:10 251:9 260:15  <b>Signal</b> [3] 112:12 113:2  113:20  <b>signature</b> [1] 198:15  <b>signed</b> [9] 9:1 38:21  43:22 225:11,17 245:5  288:1 302:8 403:21  <b>significant</b> [9] 148:7  151:19 154:6 303:22  311:19 313:13 451:19,22  451:22  <b>significantly</b> [2] 33:20  34:4  <b>signing</b> [2] 126:15 230:5  <b>similar</b> [10] 130:4 231:18  232:23 283:4 284:22  289:17 411:13 432:7  434:20 435:1  <b>Simmons</b> [93] 1:10 2:7  28:14,14 30:14 180:24  181:14 387:10,12,17  413:4,19,23 414:3 424:24  424:25 425:1,7,22 426:10  426:14,19,24 427:7,16  427:23 428:2,11,16,21  429:14,21 430:11 431:8  431:13,19 432:18 433:22  434:8 435:3,9,15 436:2  436:9,17 437:11,18  438:13,19,23 439:17,25  440:11,17,23 441:4,10  441:15 442:3,9,20 443:3  443:11,21 444:2,9,18  445:1,6,11,21 446:3,7  446:19 447:2,19 448:1,7  448:12,23 449:10,16,20  450:2,15 451:7 452:4,18  452:25 453:23 454:23  455:8,17  <b>simply</b> [2] 344:16 356:18  <b>Sinai</b> [23] 22:16 24:13,20  30:12 36:7 42:19 45:12  49:16 68:6 116:22 151:17  201:8 243:2 254:10  310:12,17 314:16 344:14  359:20 365:25 371:2  409:3 440:13  <b>Singleton</b> [6] 205:4,15  259:8 341:2 342:12 343:7  <b>Singleton's</b> [1] 341:8  <b>sit</b> [4] 35:2 304:15 400:25  456:14  <b>site</b> [1] 274:9  <b>sitting</b> [4] 78:19 81:23  266:4 297:25  <b>situation</b> [34] 63:7 67:4  69:12 76:11 78:6,7 91:25  127:3 168:9 195:10 210:8  258:22 266:12 284:8,11</p>	<p>284:22,25 287:12 295:25  348:8 353:18 367:11,21  372:24 385:6 392:22  397:6,14,24 400:7,10  411:13 433:11 439:14  <b>situations</b> [9] 91:17,20  290:9 348:7 390:3,19  400:3 402:3 404:6  <b>six</b> [10] 20:8 304:7 349:2  352:13 356:21 385:20,25  416:5 425:14 429:23  <b>skill</b> [1] 154:2  <b>slide</b> [3] 276:9 374:3,19  <b>slides</b> [2] 227:11 373:25  <b>slightly</b> [1] 374:12  <b>slip</b> [1] 312:25  <b>Sloan-Kettering</b> [3]  310:13,18 314:16  <b>small</b> [2] 243:9 323:17  <b>smaller</b> [1] 321:24  <b>Smith</b> [13] 60:8 74:12  94:19 194:14 261:23  265:23 266:2,13 267:8  267:12,13 362:12 453:11  <b>Smith's</b> [1] 263:15  <b>snarled</b> [1] 397:11  <b>Society</b> [2] 1:15 278:1  <b>software</b> [1] 306:22  <b>solely</b> [3] 106:23 353:19  404:12  <b>solicitor</b> [1] 19:20  <b>solicitor-client</b> [3]  181:7 182:2 183:1  <b>someone</b> [30] 36:8 39:13  39:19 44:7 62:9,22 63:20  64:11 74:21 122:15,16  123:2 135:3 143:2 190:18  206:3 208:23 209:7 236:6  266:8 293:2 302:9 307:16  312:21 314:3 331:23  401:2 402:5 416:18  436:11  <b>sometimes</b> [5] 88:23  332:3 333:8 336:6 447:14  <b>somewhat</b> [2] 206:5  272:9  <b>somewhere</b> [3] 151:18  256:20 420:12  <b>soon</b> [4] 185:6 348:13  409:19 420:15  <b>SOPs</b> [1] 124:10  <b>sorry</b> [19] 8:3 61:15  65:12 73:11 110:10  116:16 119:1 188:15  229:13 241:1 259:23  260:20 265:5,6 328:25  340:1,3 418:4 446:18  <b>sort</b> [13] 160:1 275:8  285:4 291:17 292:19  296:25 300:20 333:2  340:16 354:16 405:4  455:18 456:21  <b>sorts</b> [1] 431:15  <b>sought</b> [5] 26:4 344:23  346:16 393:13 395:21  <b>sound</b> [2] 24:13 458:10</p>	<p><b>sounds</b> [4] 24:6 49:25  212:14 441:5  <b>source</b> [8] 23:13 44:2  87:20 226:7 227:14  228:19 231:10 372:20  <b>sources</b> [3] 273:25  310:11 314:15  <b>Southcott</b> [2] 112:15  146:17  <b>speak</b> [19] 93:4 102:7  107:4,11 115:23 117:14  167:9 169:22 170:5  175:15,17 278:7 347:4  350:19 421:23 429:16  430:2 433:8 447:23  <b>speaking</b> [13] 12:23,24  81:24 94:19,20 98:5  101:18 200:25 201:2  262:19 272:22 447:16  448:3  <b>speaks</b> [2] 233:13 389:1  <b>special</b> [1] 452:11  <b>specialist</b> [2] 202:7,16  <b>specific</b> [5] 330:10  332:23 348:11 359:4  404:9  <b>specifically</b> [8] 41:7  53:23,25 67:22 257:4  277:7 340:8,13  <b>specifics</b> [2] 181:24  318:16  <b>specimen</b> [14] 30:25  33:14 36:9 255:23 300:11  307:16 366:1 367:9  371:24 372:20 375:1  378:2,15,18  <b>specimens</b> [9] 237:23  238:4 252:11 254:11  272:24 371:15,25 378:16  386:7  <b>speculate</b> [1] 11:24  <b>speculative</b> [1] 304:3  <b>speed</b> [1] 99:4  <b>spelling</b> [1] 131:12  <b>spells</b> [1] 282:8  <b>spent</b> [1] 247:13  <b>spiralling</b> [1] 214:20  <b>spoke</b> [11] 108:12 134:12  163:17 175:13 262:9  314:22 326:5 343:10  350:19 450:4 456:12  <b>spoken</b> [6] 108:17,19  178:18 181:11 185:3  261:20  <b>sponsored</b> [1] 436:13  <b>spot</b> [2] 127:15 293:8  <b>spreadsheet</b> [1] 112:14  <b>spreadsheets</b> [1] 34:21  <b>spring</b> [5] 52:1 194:7  216:17 383:1 449:22  <b>St</b> [5] 278:6 279:3 281:5  458:7,11  <b>staff</b> [9] 37:20 93:13  116:21 267:6 296:4  304:25 308:6 337:15  432:16</p>	<p><b>stage</b> [7] 17:3 51:18 54:2  60:13 117:20 118:1  122:17  <b>stages</b> [1] 308:20  <b>stain</b> [1] 286:25  <b>staining</b> [5] 228:5 375:13  375:13,23 426:6  <b>stand</b> [4] 2:2 4:3 93:22  165:24  <b>standard</b> [10] 18:16  117:18 118:15,17 338:20  428:23 429:1,7,8,11  <b>standards</b> [2] 429:6,16  <b>start</b> [9] 6:14 128:24  140:24 231:24 277:17,21  293:20 373:25 406:5  <b>started</b> [12] 84:6,14  144:15,16 152:10,13  157:13 191:1 233:4  296:21 456:4,17  <b>starting</b> [3] 6:10 278:2  403:13  <b>starts</b> [3] 5:24 28:14  237:20  <b>state</b> [2] 102:25 106:12  <b>statement</b> [22] 15:15  43:24 44:10 49:3 71:9  72:6,12 163:16,24 166:5  169:1 176:3 221:16 238:8  241:8,22 249:15 394:23  426:21 428:17 429:25  453:17  <b>statements</b> [3] 99:16  241:3 393:4  <b>states</b> [5] 264:11 317:10  416:5 419:2 422:2  <b>stating</b> [3] 236:17 396:15  453:19  <b>statistical</b> [3] 155:13,17  411:6  <b>statistics</b> [2] 291:21  417:5  <b>status</b> [7] 13:22 20:16  24:8 42:16 45:7 107:3  223:10  <b>stay</b> [3] 91:1 247:18  256:9  <b>stayed</b> [1] 135:25  <b>Steering</b> [1] 205:17  <b>step</b> [4] 327:24 328:3,6  397:4  <b>steps</b> [5] 19:10 49:8  333:21 356:1 456:23  <b>sterilization</b> [3] 436:20  436:24 437:3  <b>Stewart</b> [1] 199:25  <b>stick</b> [1] 273:15  <b>sticks</b> [3] 39:18 112:21  398:13  <b>still</b> [30] 13:18 14:12,18  69:10 93:12 99:25 103:22  122:11 128:2 143:5  144:21 198:20 213:17  236:8 241:15,25 250:3  285:4 302:16 324:4  339:19 341:10 355:7</p>	<p>361:2 368:24 377:18  380:25 381:17 409:11  415:15  <b>stood</b> [1] 323:19  <b>stop</b> [5] 31:17 75:8  231:24 328:11 390:10  <b>stopped</b> [1] 233:5  <b>stopping</b> [1] 207:13  <b>story</b> [11] 66:13 83:2  202:1,4 212:10 214:25  215:3,9 439:13 440:5  442:6  <b>straight</b> [2] 250:17  439:13  <b>straightforward</b> [1]  76:10  <b>strategies</b> [1] 434:25  <b>stray</b> [2] 181:7 183:1  <b>straying</b> [1] 182:2  <b>street</b> [1] 209:7  <b>stress</b> [4] 22:16,23 47:11  93:2  <b>strike</b> [6] 273:17 319:24  320:2 353:15 355:8  365:15  <b>strong</b> [8] 78:1 418:4,10  421:11,12 426:3,6 434:17  <b>stronger</b> [1] 380:7  <b>strongly</b> [1] 138:15  <b>struck</b> [6] 43:11 141:17  141:21 152:11 154:14  157:20  <b>structure</b> [2] 101:24  206:3  <b>Student</b> [1] 453:2  <b>stuff</b> [1] 324:1  <b>sturdy</b> [1] 388:17  <b>style</b> [3] 111:15 114:15  114:25  <b>sub</b> [1] 308:22  <b>subject</b> [10] 45:17 73:19  86:19 89:1 96:20,22  127:20 139:4 197:20  365:2  <b>submitting</b> [1] 419:1  <b>subscribers</b> [1] 437:7  <b>subsequent</b> [9] 12:19  194:3 279:23 280:13  342:1 363:10 414:21  433:19 453:10  <b>subsequently</b> [5] 109:6  142:12 279:20 299:1  301:11  <b>substance</b> [1] 133:18  <b>substantive</b> [1] 138:16  <b>substitution</b> [1] 336:18  <b>subtract</b> [1] 139:16  <b>subtracted</b> [1] 137:22  <b>success</b> [1] 151:4  <b>successful</b> [1] 191:10  <b>succinctly</b> [1] 264:24  <b>such</b> [27] 72:5,11 76:11  83:11 113:18 127:3  146:25 181:4 205:23</p>
--	---	--	--	--

**Inquiry on Hormone Receptor Testing**

<p>207:20 222:12 227:4 258:22 282:9 283:19 285:15 299:16 300:10 318:7 345:4 356:13 365:6 375:19 399:5 423:12,16 457:14</p> <p><b>suffered</b> [1] 47:11 <b>suffering</b> [1] 400:17 <b>sufficient</b> [1] 316:18 <b>sugar</b> [1] 209:13 <b>suggest</b> [4] 76:11 149:11 316:16 394:22 <b>suggested</b> [9] 78:4 98:21 114:15 199:25 230:7 234:20 258:9 353:2 424:9 <b>suggesting</b> [3] 230:25 256:24 423:14 <b>suggestion</b> [3] 105:15 135:2 257:6 <b>suggestions</b> [3] 71:1 137:2 323:16 <b>suing</b> [2] 79:12 82:17 <b>suit</b> [5] 115:25 175:17 178:6 246:2,17 <b>suits</b> [1] 163:6 <b>summary</b> [9] 23:7 45:2 70:25 97:5 102:16 127:24 129:20 132:1 242:10 <b>summer</b> [7] 70:6 124:6 124:6 309:10 356:13 359:7 456:9 <b>superficial</b> [1] 142:2 <b>supper</b> [1] 212:12 <b>support</b> [4] 114:23 266:10,11 324:5 <b>supports</b> [3] 327:9,20 329:4 <b>supposed</b> [3] 82:6 171:22 185:18 <b>surgeon</b> [1] 268:21 <b>surgery</b> [3] 42:9 408:25 433:9 <b>surgical</b> [2] 231:17 232:24 <b>surprise</b> [4] 52:25 53:4 316:15 356:17 <b>surprised</b> [9] 37:6 203:8 216:22 217:6 315:9,13 353:13 355:6,8 <b>surrounded</b> [1] 445:24 <b>surrounding</b> [1] 342:5 <b>survey</b> [1] 430:24 <b>Susan</b> [17] 74:11 97:25 129:19 137:14 144:6 145:20 156:12 157:18 158:1,9,16 159:13 163:7 165:7 168:16 199:22 224:3 <b>suspecting</b> [1] 139:5 <b>sustain</b> [1] 120:22 <b>sustained</b> [2] 119:21 124:12 <b>swirl</b> [2] 399:22,24 <b>swiss</b> [4] 328:8,14 331:3 333:15</p>	<p><b>switched</b> [2] 74:17 298:18 <b>synopsis</b> [1] 254:7 <b>system</b> [22] 18:3 121:4 227:7 288:17 305:16 306:3,4,8,13,19 308:15 308:16,21 311:4 318:10 319:12 335:23 336:7,13 353:1 389:20 433:12 <b>systemic</b> [2] 195:17 333:2 <b>systems</b> [2] 308:18 389:8</p> <hr/> <p style="text-align: center;"><b>-T-</b></p> <hr/> <p><b>table</b> [17] 2:1 15:1 29:3 31:15 33:23 34:12 36:18 42:18 78:20 283:1 372:13 398:13 417:2,18 418:3 419:25 425:25 <b>tables</b> [1] 417:2 <b>takes</b> [2] 201:25 328:10 <b>taking</b> [18] 6:6 26:1 48:15 64:21 142:21 247:23 263:19 264:20 266:2 276:24 305:1 312:21 314:4 352:4 356:1 356:15 444:14 449:11 <b>talks</b> [2] 316:3 431:10 <b>Tamoxifen</b> [36] 19:2,4 19:4 25:2 29:11,12,17 29:20,24 30:23 31:11,15 33:12,23 41:15 48:7 49:1 69:3 74:16 133:2 156:5 156:8,9 159:3 210:5 254:20 256:2,13 260:12 348:18 357:17 367:24 368:8 408:17,21 409:5 <b>task</b> [1] 10:25 <b>tasked</b> [5] 104:25 269:14 402:1,6 403:13 <b>tasks</b> [1] 11:6 <b>taxonomy</b> [1] 305:19 <b>team</b> [5] 117:15 126:25 127:9 208:7 447:15 <b>technical</b> [27] 143:10 145:25 146:7 148:3 150:11 152:22 154:5 180:13 184:11,25 186:23 226:2,3,12 227:13 228:11 228:14,25 229:4,10,19 341:7,13 371:8,10,21 380:1 <b>technically</b> [1] 153:24 <b>technologist</b> [1] 321:1 <b>technologists</b> [6] 227:5 227:8 316:12 321:7 325:9 326:1 <b>technology</b> [15] 317:10 317:17,23,25 318:2,9,21 319:1,23 320:12 321:21 322:13 342:4 388:14,17 <b>techs</b> [1] 310:3 <b>telephone</b> [5] 55:12 63:2 165:14 241:7 443:24 <b>telephoned</b> [1] 237:23 <b>telling</b> [17] 76:18,20</p>	<p>114:19 139:3 189:20 215:25 222:1,6 250:16 251:12 301:12 334:18,23 343:16 345:3 404:14 454:19 <b>templates</b> [1] 198:19 <b>ten</b> [23] 23:4,7 79:19 124:17 186:4,5,8,11 187:2,8 215:18 277:16 277:18 311:25 319:10 379:13,13,22 417:10,12 451:22 453:8,16 <b>tend</b> [1] 99:13 <b>tender</b> [1] 423:23 <b>tends</b> [3] 4:21 5:1 99:16 <b>tentative</b> [1] 194:24 <b>term</b> [4] 122:4 130:8,20 376:21 <b>terminology</b> [2] 279:6 429:9 <b>terms</b> [36] 11:5 15:2 25:25 27:17 36:25 47:17 76:6 87:15 102:9 103:11 106:15 108:21 110:23 117:17 118:15 126:6 134:9 135:24 136:20 145:22 178:7 179:7 184:2 184:24 185:3 218:11 226:18 236:16 249:4 259:1 260:4 290:12 308:10 310:20 351:5 375:19 <b>terrible</b> [1] 337:25 <b>Terry</b> [5] 74:10 109:25 114:10 252:17,18 <b>test</b> [40] 13:20 23:11 29:3 30:11 31:4 33:19 41:13 42:1,10,20 45:8 47:10 83:6 84:21 118:16 126:13 136:16 138:23,24 147:17 147:19 150:4,12 153:2 155:10 201:5 210:6,17 227:10 239:19 274:6,7 300:19 303:9,10 307:8 318:4 336:18 404:21 449:24 <b>tested</b> [6] 51:22,22 58:15 58:25,25 255:15 <b>testified</b> [3] 346:6 370:10 407:12 <b>testimony</b> [1] 260:9 <b>testing</b> [32] 1:2,13 20:17 22:15 47:12 52:11 98:5 101:19 109:11 111:14 112:1 116:19,19,22 122:13,14,19 126:18 210:3,4,16 212:2 233:19 268:17,19 315:9,18 316:6 323:24 339:21 342:6 458:4 <b>tests</b> [15] 24:9 46:17 127:7 170:23 174:16,24 175:2,4 227:6 231:22,25 233:3 362:8 426:3,5 <b>text</b> [2] 133:17,19 <b>thank</b> [46] 31:10 43:20 61:15,17 91:7 133:23 134:6 210:10,12 211:17</p>	<p>233:23 251:7 271:7,9,11 271:14,19 277:13,15 294:3 295:10,13 297:18 315:2 335:11 347:22 367:22 387:4,7 388:13 388:18 408:4 410:3 414:17 417:17 424:20,24 449:19 453:24 454:3,5 454:19 457:3,8,15,17 <b>thanks</b> [3] 14:5 212:8 415:1 <b>the-when</b> [1] 75:15 <b>themselves</b> [5] 19:20 58:3 295:19 342:18 356:1 <b>Therapeutics</b> [1] 117:7 <b>therapy</b> [5] 33:22 34:5 34:11 75:7 367:17 <b>thereabout</b> [1] 186:12 <b>thereabouts</b> [1] 244:7 <b>thereafter</b> [2] 124:7 145:24 <b>thereby</b> [1] 430:1 <b>therefore</b> [3] 75:2 410:8 430:18 <b>they've</b> [5] 173:6 334:24 369:4,5 403:17 <b>thinking</b> [27] 9:8 63:7 63:23 64:6 84:14 131:1 141:16 142:12 152:10,13 154:7 165:22 167:2 168:2 202:13 209:10 213:6 215:12,24 217:8 231:4 282:25 319:19 320:10 357:3 392:6 400:7 <b>thinks</b> [1] 29:6 <b>thinning</b> [1] 48:22 <b>third</b> [8] 21:23 234:1 367:17 406:19 407:12 429:24 437:25 456:5 <b>Thirdly</b> [1] 13:21 <b>Thompson</b> [12] 37:20 234:3,3 237:17,17 240:17 241:2,22 242:7,16 243:16 270:2 <b>thought</b> [33] 12:7 53:5 53:18 96:8 101:8 111:24 122:13 145:3 155:2,8 156:13 167:3,5 182:6 209:9 216:19 255:21 276:23 318:7,23 323:12 325:23 335:1 351:9 359:7 374:2 396:24 405:22,24 421:1,24 439:15 456:6 <b>thoughts</b> [1] 240:8 <b>thousand</b> [1] 308:24 <b>three</b> [21] 34:10 68:9 154:12 159:16 160:2 171:13 172:19 173:1 232:6 244:6 258:5 260:20 279:20 286:18 349:10 356:21 358:14 373:10,12 424:4 453:6 <b>through</b> [103] 7:15 9:4 9:23 11:13 12:7 16:8 32:7,8 34:19 36:10 38:18 39:23 41:2 48:20 60:6 60:18 62:16 65:7 66:13</p>	<p>67:15,19 75:19 77:20,22 78:17 89:6 93:14 103:9 103:19 104:10 105:16 109:25 110:18 111:11 114:18 117:10,22 137:11 138:2,4,21 140:13 141:11 144:15,20 152:12 157:20 161:3 164:1 166:14 167:11 168:6 184:17,18 184:20 189:7 195:16 196:8 204:14 208:22 234:5 236:15,18 244:22 252:25 255:21 262:10 264:3,22 266:23 286:9 286:19 287:23 289:15 301:9 305:8 307:3 323:22 325:13 336:11 341:24 355:9,13 362:21 364:22 378:20 384:3 385:20 393:12 395:11,25,25 400:25 401:7 402:11 404:4 419:3,24 433:23 437:9,10 445:15 450:10 <b>throughout</b> [4] 86:8 277:9 444:10 450:7 <b>Thursday</b> [1] 247:12 <b>Tilley</b> [27] 73:1,2,16,19 95:3 109:21 110:2,11 112:9,12,25 113:13 212:1 212:21 221:25 222:2,6 222:20 223:10 234:3,24 235:2,14 240:7 242:7,16 395:9 <b>timeframe</b> [1] 439:10 <b>timeliness</b> [1] 389:14 <b>timely</b> [2] 284:6 286:16 <b>times</b> [12] 68:10 141:20 145:20 155:3 279:20 311:25 319:10 331:5 354:23 421:15 449:21 450:8 <b>timing</b> [2] 97:9 382:24 <b>tired</b> [2] 355:12 387:25 <b>tissue</b> [3] 226:5 409:1 448:18 <b>title</b> [1] 389:1 <b>today</b> [15] 14:15 68:12 69:24 93:20 127:22 128:2 201:1 210:14 212:9 252:3 258:11 272:3 284:23 356:25 388:4 <b>today's</b> [1] 242:10 <b>together</b> [11] 97:17 98:22 155:1 159:14,16 262:5 417:14 430:21 432:1,6 456:18 <b>token</b> [1] 274:19 <b>Tolton</b> [1] 433:8 <b>tomorrow</b> [4] 208:18 416:15 422:15 423:23 <b>tongue</b> [1] 312:25 <b>too</b> [6] 156:21 215:21 216:18 298:9 316:22 443:19 <b>took</b> [11] 32:7 89:17,18 103:25 108:3 184:20 202:14 255:17 265:23 393:2 439:22</p>
--	--	---	---	---

Inquiry on Hormone Receptor Testing

<p><b>tool</b> [7] 297:19 298:18,24 306:5,9 321:14 437:10</p> <p><b>tools</b> [3] 336:10 434:13 434:19</p> <p><b>top</b> [6] 5:11 107:13 125:14 206:10 283:1 365:10</p> <p><b>topic</b> [1] 223:23</p> <p><b>topics</b> [4] 280:5 309:18 404:20 433:25</p> <p><b>tops</b> [2] 212:5 213:1</p> <p><b>torn</b> [1] 218:21</p> <p><b>total</b> [16] 5:19 42:17 83:3 83:18 84:2 129:4 139:14 140:25 170:23 214:7 301:8 357:24 379:17 418:18 426:2,15</p> <p><b>totally</b> [5] 91:18 212:4 212:25 218:21 304:2</p> <p><b>touch</b> [5] 39:5 56:15 62:9 63:20 344:20</p> <p><b>towards</b> [2] 7:9 186:1</p> <p><b>town</b> [2] 13:15 419:9</p> <p><b>track</b> [13] 27:1 69:21 113:18,19 139:20 261:19 287:1,22 290:21 292:16 297:10 354:1 355:23</p> <p><b>tracking</b> [1] 405:14</p> <p><b>trained</b> [1] 121:14</p> <p><b>training</b> [2] 316:12,17</p> <p><b>transcribed</b> [1] 458:9</p> <p><b>transcript</b> [5] 51:5 407:14,21 408:11 458:3</p> <p><b>treated</b> [11] 31:11 74:16 141:24 257:1 361:14 367:24 368:8 369:11 377:6 410:7,8</p> <p><b>treating</b> [3] 268:22 302:25 409:16</p> <p><b>treatment</b> [71] 13:23 19:2 24:12 30:24 31:15 33:13 34:1 35:22,23 41:14 45:11 48:6 69:2 76:20,22 78:19 82:13 83:23,25 84:11,12,16 86:2 89:19 149:12,21,24 151:25 156:10,22 159:6 160:14,24 161:6,18,20 162:9 302:23 303:8,10 303:23 344:16 345:11 348:4,6,12,14,15,22 349:8 350:8,10 351:6,12 352:7,11,16 356:20 361:4 363:18 364:9,11 366:8 368:18 369:6 381:3,17 389:15 394:10 409:13,14</p> <p><b>trend</b> [1] 288:6</p> <p><b>trending</b> [1] 433:20</p> <p><b>trends</b> [1] 307:12</p> <p><b>tried</b> [4] 139:24 215:8 404:10 405:1</p> <p><b>triple</b> [1] 194:23</p> <p><b>Trish</b> [1] 272:7</p> <p><b>trouble</b> [1] 149:23</p> <p><b>troubleshooting</b> [1] 316:15</p>	<p><b>true</b> [9] 22:11 52:3 61:10 142:24 239:12 357:19 364:2 416:17 458:3</p> <p><b>Trustee</b> [1] 212:22</p> <p><b>truth</b> [1] 366:17</p> <p><b>try</b> [20] 35:2 99:3 103:7,8 129:22,24 139:9 237:10 241:21 246:6 258:11 283:3 285:4 295:23 298:2 298:4,8,15 304:15 320:18</p> <p><b>trying</b> [30] 9:4 11:25 27:25 41:8 60:3 114:20 140:2 157:15 187:9 189:5 189:17 208:10,11 213:23 215:7 217:11 221:5 240:12 243:21 247:14 250:6 253:2 265:7 298:12 311:11,15 359:3 400:5 456:3,22</p> <p><b>Tuesday</b> [1] 98:14</p> <p><b>turn</b> [4] 213:3 214:14,24 216:22</p> <p><b>turns</b> [1] 293:15</p> <p><b>twice</b> [2] 20:24 52:21</p> <p><b>twiggled</b> [1] 9:19</p> <p><b>two</b> [60] 5:11 6:2 8:11 18:17 21:14,17 25:1,17 25:22 29:9 43:14 48:3 77:2 91:17,18,20 109:22 129:6 152:21 153:22 159:24 214:6 224:9 245:18 249:24 250:1,14 252:3 267:24 274:7 282:18 294:3,11 315:20 362:22 363:10 370:15 371:15 373:14 378:9,15 378:16 380:18,23 383:14 385:16 386:7 393:17 402:18 409:11 416:3 417:2,4,5 418:2 424:9 433:7 434:19 439:15 456:21</p> <p><b>type</b> [43] 24:15 30:19,19 40:24 41:8 44:2,10 47:18 63:14,25 64:17 76:19 100:12 141:19 152:17,17 152:18 153:7 174:15 227:9 246:11 253:20 284:25 288:20 297:1,8 298:17 302:23 303:9 304:8 308:4 320:11 333:2 336:21 337:20 400:7,10 402:24 441:5 450:20 451:3,3,6</p> <p><b>typed</b> [1] 141:16</p> <p><b>types</b> [13] 214:18 289:9 290:20 292:19 295:24 298:4 305:23 307:23 320:23 322:2 323:2 339:13 348:3</p> <p><b>typically</b> [5] 78:5 327:6 328:5,8 348:25</p> <p><b>typing</b> [1] 289:7</p> <p><b>typo</b> [1] 270:14</p> <hr/> <p style="text-align: center;"><b>-U-</b></p> <hr/> <p><b>U</b> [1] 433:16</p> <p><b>uh-hm</b> [21] 26:24 56:22</p>	<p>57:4 129:10 282:23 290:5 320:7,15 325:17 327:12 330:13 331:25 332:6 336:15,23 337:13,18 338:23 372:10 429:15 450:16</p> <p><b>ultimate</b> [2] 260:3 333:11</p> <p><b>ultimately</b> [8] 97:14 122:2 185:16 261:23 301:23 344:20 361:3 366:21</p> <p><b>Um-hm</b> [6] 165:20 346:25 381:7 386:5 417:1 420:10</p> <p><b>umbrella</b> [2] 389:24,25</p> <p><b>unanimous</b> [1] 205:25</p> <p><b>unaware</b> [1] 195:9</p> <p><b>uncertain</b> [1] 182:23</p> <p><b>unclear</b> [1] 261:22</p> <p><b>Undated</b> [1] 412:22</p> <p><b>under</b> [15] 14:12,18 17:20 93:3 108:6 116:1 139:13 206:20 240:17 241:22 248:20 315:17 342:2 429:24 445:23</p> <p><b>undergoing</b> [1] 359:6</p> <p><b>underlying</b> [1] 446:11</p> <p><b>undermine</b> [3] 166:10 166:19 167:23</p> <p><b>understand</b> [56] 4:18 11:25 37:18 51:18 52:3 55:18,24 86:12 87:14 88:10 95:4 107:11 115:9 115:15 117:2,25 118:1 121:17 136:16 144:25 148:6 151:2 160:21 164:11 167:20 174:25 176:8 178:23 194:7 200:25 203:25 217:3 218:1 220:16 245:6 251:12,17 253:13 269:12 280:6 284:23 329:22 332:3 348:3,24 357:8,13 357:14 360:21 387:9 408:9 427:8 429:15 432:21 442:24 452:8</p> <p><b>understands</b> [1] 286:10</p> <p><b>understood</b> [17] 26:6 26:21 52:1,6 64:24 89:21 104:24 253:16 269:13 279:1 311:23 345:3 346:19 350:1 360:16 442:22 453:18</p> <p><b>undertake</b> [1] 196:16</p> <p><b>undertaken</b> [1] 196:21</p> <p><b>undertaking</b> [1] 274:15</p> <p><b>undertook</b> [1] 401:21</p> <p><b>underway</b> [3] 358:1,24 359:6</p> <p><b>unequivocal</b> [1] 275:20</p> <p><b>unfold</b> [2] 216:12,19</p> <p><b>unfolding</b> [2] 214:25 215:4</p> <p><b>unfortunate</b> [1] 193:1</p> <p><b>unfortunately</b> [7] 65:4</p>	<p>192:10 208:9 275:10 328:10 395:23 408:23</p> <p><b>unique</b> [1] 258:22</p> <p><b>unit</b> [5] 152:16 155:6 449:23 450:18 452:14</p> <p><b>University</b> [1] 453:2</p> <p><b>unless</b> [10] 14:20 32:25 59:9 60:1 61:23 66:5 78:1 276:3 355:20 430:17</p> <p><b>unnerved</b> [1] 237:18</p> <p><b>unprecedented</b> [2] 136:12 168:14</p> <p><b>unqualified</b> [1] 275:19</p> <p><b>unsuccessful</b> [1] 339:7</p> <p><b>unusual</b> [10] 89:5 107:20 112:23 125:12,23 281:16 357:3 367:11,23 368:5</p> <p><b>up</b> [148] 4:24 5:11 9:9 24:18 26:12 27:6 30:6 33:3 36:11 37:12,19 39:13 56:24 58:19 59:5 59:18 63:15 64:1 66:9 69:16 70:11 81:8 92:9 93:12 96:22 98:24 99:4 106:13 109:2 112:11,16 113:2,11,20 114:25 115:2 116:17 120:16 123:5 127:20 130:11,19 131:14 131:18 132:6,19 134:8 137:12 138:13 140:3,10 140:15 145:19 148:24 156:20,25 157:15 158:9 165:1,24 168:18 175:13 175:15 186:9,22,23 187:1 187:9 193:13 195:7 197:8 202:11,12 208:20 212:9 214:18 215:6 227:20 229:4 234:22 238:6,10 239:23 241:21 242:3,20 243:18 244:20 249:21 250:10 255:2 256:4,21 260:2 261:23 263:11,20 264:4,18 269:11 271:2 272:17 273:9 276:18 278:9 279:9,18 282:1 286:2,4,7 287:22 288:10 289:8 293:12 304:1 311:15 316:20 328:18 331:2 335:25 341:3 346:9 346:12 352:20 360:17 362:11 364:21 368:24 370:14 371:17 377:24 379:1 384:1 388:16 397:11 405:1 417:9,10 420:23 424:4 430:25 437:20 440:1 441:11 453:19 455:19 456:11</p> <p><b>update</b> [5] 6:14 50:9 108:21 219:7 257:17</p> <p><b>updated</b> [19] 61:25 102:18 105:4,11,18,21 106:16,25 108:24 109:1 109:2,6,15,23,24 110:23 111:10 113:25 122:10</p> <p><b>updates</b> [2] 111:5 342:1</p> <p><b>updating</b> [6] 106:15 110:1,25 111:3,12 358:25</p> <p><b>upfront</b> [1] 239:8</p> <p><b>upgrades</b> [1] 227:8</p>	<p><b>upset</b> [6] 39:9,14,21 79:17,24 252:4</p> <p><b>upsetting</b> [2] 79:25 80:7</p> <p><b>upshot</b> [1] 273:22</p> <p><b>urgency</b> [1] 113:17</p> <p><b>used</b> [12] 28:21 86:8 130:6 148:25 228:4 298:18 321:1 368:16,24 379:24 388:14 437:9</p> <p><b>using</b> [11] 6:10 28:6 85:16 130:16 141:1 147:15,17 231:23 233:4 306:8 325:14</p> <p><b>usual</b> [2] 25:15 75:2</p> <p><b>usually</b> [3] 25:23 175:17 290:18</p> <p><b>utilization</b> [1] 389:22</p> <p><b>utilize</b> [1] 403:6</p> <hr/> <p style="text-align: center;"><b>-V-</b></p> <hr/> <p><b>vague</b> [8] 12:25 15:21 18:23 19:23 20:22 38:23 55:11 187:25</p> <p><b>validated</b> [1] 25:19</p> <p><b>validity</b> [1] 276:4</p> <p><b>validly</b> [1] 61:1</p> <p><b>value</b> [4] 101:11 155:14 155:16 275:21</p> <p><b>variation</b> [1] 394:10</p> <p><b>variety</b> [5] 236:8 255:18 334:1,9 338:12</p> <p><b>various</b> [10] 6:19 56:24 134:10 278:3 307:25 310:11 311:12 322:25 336:10 393:4</p> <p><b>vast</b> [1] 256:11</p> <p><b>Ventana</b> [7] 311:24 312:3,18 319:10,12 320:4 322:5</p> <p><b>verbal</b> [2] 54:20 341:19</p> <p><b>verbalized</b> [1] 25:8</p> <p><b>verbally</b> [1] 297:7</p> <p><b>verification</b> [3] 89:15 345:17 353:14</p> <p><b>verified</b> [1] 312:15</p> <p><b>verify</b> [3] 32:8 374:7 405:2</p> <p><b>Verna</b> [1] 18:19</p> <p><b>versa</b> [1] 310:5</p> <p><b>versed</b> [1] 309:18</p> <p><b>verses</b> [1] 312:1</p> <p><b>version</b> [19] 4:19 6:11 6:17 8:4 20:3 37:19 38:9 110:12 113:25 132:6,8 134:7,19 225:13,16,17 319:1 453:4,5</p> <p><b>versions</b> [1] 109:7</p> <p><b>versus</b> [6] 35:22 285:13 375:13 387:25 394:10 425:19</p> <p><b>via</b> [3] 62:20 75:1 293:15</p> <p><b>vice</b> [1] 310:5</p> <p><b>video</b> [1] 293:15</p>
--	---	--	--	--

<p><b>view</b> [19] 31:12 33:25 56:2 95:7 106:13 124:7 179:15 212:16 275:17 280:11 357:11,13 364:2 366:13 371:8,11 430:23 444:4 456:23</p> <p><b>views</b> [2] 183:8 393:12</p> <p><b>virus</b> [1] 323:25</p> <p><b>visit</b> [3] 112:4 350:11 353:13</p> <p><b>visualize</b> [2] 298:15 355:12</p> <p><b>vogue</b> [1] 298:20</p> <p><b>voice</b> [3] 210:14 213:10 220:15</p> <p><b>volume</b> [1] 78:16</p> <p><b>VP</b> [2] 127:10 222:11</p> <hr/> <p style="text-align: center;"><b>-W-</b></p> <hr/> <p><b>Wade</b> [1] 290:1</p> <p><b>wait</b> [12] 22:18 47:13 345:14 352:13 353:12 355:11 356:21 359:1 381:24 383:7 409:17 439:3</p> <p><b>waited</b> [2] 79:19 215:17</p> <p><b>waiting</b> [8] 52:5,7,14 202:16 252:2,5 353:16 355:25</p> <p><b>walk</b> [1] 103:9</p> <p><b>walking</b> [5] 16:8 89:6 112:11 113:2,20</p> <p><b>wall</b> [1] 262:15</p> <p><b>wanting</b> [2] 201:21 446:20</p> <p><b>wants</b> [3] 203:18 213:14 213:17</p> <p><b>warrant</b> [4] 33:21 34:4 374:25 376:12</p> <p><b>watch</b> [3] 213:4,23 323:22</p> <p><b>Wayne</b> [1] 358:10</p> <p><b>ways</b> [1] 56:24</p> <p><b>weak</b> [5] 259:25 260:4 417:8,14 426:6</p> <p><b>weaker</b> [1] 380:11</p> <p><b>wear</b> [2] 122:25 424:9</p> <p><b>Wednesday</b> [1] 247:8</p> <p><b>week</b> [9] 110:1 147:7 149:10 188:5 201:16 317:8 326:5 359:22 454:22</p> <p><b>weekly</b> [1] 352:24</p> <p><b>weeks</b> [3] 91:18 245:18 409:11</p> <p><b>Wegrynowski</b> [6] 179:2 194:1 273:23 276:18 342:10 445:14</p> <p><b>Wegrynowski's</b> [1] 272:8</p> <p><b>weight</b> [3] 9:17 10:14 11:18</p> <p><b>welcome</b> [1] 424:22</p> <p><b>well</b> [1] 150:12</p>	<p><b>Western</b> [4] 1:16 272:1 276:19 432:4</p> <p><b>wheedled</b> [1] 363:16</p> <p><b>wherever</b> [1] 293:5</p> <p><b>white</b> [3] 211:15 280:23 302:20</p> <p><b>who'd</b> [1] 256:12</p> <p><b>whole</b> [14] 11:4 16:8 38:23 106:22 159:2 162:8 243:20 282:2 310:18 329:21 338:25 367:21 444:10 456:8</p> <p><b>wide</b> [7] 287:11,17 288:13 290:12 291:10 304:20 308:18</p> <p><b>wife's</b> [1] 68:4</p> <p><b>Williams</b> [20] 8:16,21 12:11 13:6 244:16 315:5 341:20 347:5,12 398:12 399:8 401:3 406:23 437:22 442:15 443:13,19 444:4,8 453:18</p> <p><b>willing</b> [1] 124:14</p> <p><b>winding</b> [1] 70:11</p> <p><b>Winnipeg</b> [1] 433:10</p> <p><b>winter</b> [1] 383:1</p> <p><b>wise</b> [1] 202:13</p> <p><b>within</b> [19] 18:3 44:15 52:22 83:7 84:22 116:4 122:14 124:8 126:5 145:8 170:1 209:14 222:15 240:14 310:12 342:15 406:2 409:10 447:3</p> <p><b>without</b> [17] 34:14 65:20 67:3 69:15 80:14,14 87:1 135:10 190:15 212:19 258:20,23 320:19 323:10 356:6 366:24 393:5</p> <p><b>witness</b> [4] 271:14,19 286:9 387:11</p> <p><b>witnesses</b> [9] 181:4,11 182:7 285:17 293:14 300:8 358:14 416:12 422:15</p> <p><b>women</b> [12] 20:15 21:2 22:1,17 24:7,9 26:1 27:17 43:22 45:6,8 210:7</p> <p><b>wondered</b> [2] 88:24 130:19</p> <p><b>wondering</b> [10] 7:3 25:25 186:21 280:11 287:10 291:5 342:12 348:1 365:11 383:21</p> <p><b>word</b> [14] 27:19,19 28:2 45:18 62:10 130:4,5,11 130:16 133:9 184:14 252:5 312:14,21</p> <p><b>worded</b> [3] 254:17,22 344:6</p> <p><b>wording</b> [4] 71:1 149:3 280:6 411:1</p> <p><b>words</b> [6] 79:21 273:2 357:20 409:17 417:13 449:1</p> <p><b>worked</b> [7] 56:11 103:23 138:2,3 144:15 230:22 231:1</p>	<p><b>workload</b> [1] 284:4</p> <p><b>works</b> [6] 4:22 86:15 185:20 290:1 403:2 412:9</p> <p><b>workshop</b> [2] 207:4,25</p> <p><b>world</b> [6] 151:22,23 152:1 275:17 300:2 452:3</p> <p><b>worried</b> [1] 350:15</p> <p><b>worry</b> [1] 317:1</p> <p><b>worse</b> [5] 46:4 118:23 119:2,8 126:3</p> <p><b>worth</b> [1] 309:4</p> <p><b>write</b> [15] 61:19 70:9,10 78:22 81:9 91:9 101:18 203:12 223:19 227:1 228:10 264:24 313:12 343:18 402:1</p> <p><b>writes</b> [2] 13:15 207:16</p> <p><b>writing</b> [16] 5:2 17:14 68:2 74:13 194:14 202:4 221:24 222:6 257:16 312:10 314:25 393:8 396:4,9 400:10 401:20</p> <p><b>written</b> [13] 46:8 66:20 78:7 92:19 188:11 190:6 227:2,21 230:14 270:2 349:18,20 384:9</p> <p><b>wrong</b> [11] 138:24 142:13 149:17 174:15,16 174:24 180:1 298:12 330:4,6 337:15</p> <p><b>wrote</b> [7] 75:4 88:16 220:2 261:10 327:15 341:12 384:4</p> <hr/> <p style="text-align: center;"><b>-X-</b></p> <hr/> <p><b>X's</b> [1] 378:12</p> <hr/> <p style="text-align: center;"><b>-Y-</b></p> <hr/> <p><b>year</b> [8] 192:22,23 197:2 307:10 352:14 413:6 416:5 432:1</p> <p><b>yearly</b> [2] 349:5,7</p> <p><b>years</b> [15] 34:10 90:19 91:2 124:17 155:12 206:20 236:5 296:19 312:12 323:1 331:13 333:1,24 339:18 409:7</p> <p><b>yesterday</b> [8] 4:12 7:11 23:21 37:1 78:24 201:2 222:5 341:5</p> <p><b>yet</b> [12] 8:17 93:13 119:18 161:19 217:10 234:7 250:11 309:1 317:1 351:23 354:7 356:15</p> <p><b>yourself</b> [28] 4:13 27:11 40:21 44:23 74:8 97:22 99:4 115:7 127:18 129:18 136:7 162:6 165:7 180:19 203:12 205:3 209:24 212:2 234:24 240:7 249:22 259:25 267:12 286:20 309:23 371:4 429:12 436:4</p> <p><b>Youth</b> [1] 10:1</p> <p><b>Yvonne</b> [1] 13:17</p>	<hr/> <p style="text-align: center;"><b>-Z-</b></p> <hr/> <p><b>zero</b> [17] 68:6 84:17 365:24 366:1,3,3,3 378:19,20 379:14,14 380:20,21 385:24,24 408:15 451:16</p> <p><b>zero/zero</b> [16] 148:4 360:11 373:13 377:1 378:1,4,10,22 379:10 380:9,22 383:16 385:1 385:10,11,17</p> <p><b>Zulfiqar</b> [1] 264:8</p> <hr/> <p style="text-align: center;"><b>- -</b></p> <hr/> <p>\ [1] 24:24</p>
---	---	---	--